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ABSTRACT

This training syllabus on counseling older adults is written for educators and counselors, and can be used as a single course syllabus, for inservice training, or to supplement existing courses. The book is divided into 11 training modules, each of which includes counseling implications and strategies, concrete classroom activities, suggested modes of assessment that can be adapted for training purposes, and supplemental references. The modules cover the demographic aspects of aging, adult development changes, physiological changes and health problems of aging, psychosocial aspects of aging, adaptation of older adults, potential crisis situations (e.g., preretirement, retirement, leisure, relocation, and housing), death, minority group older adults, counseling approaches, paraprofessional peer counseling roles, counseling programs and environments, practica and internships for student counselors, and aging relevant issues, policies, and legislation. (BL)

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COUNSELING THE AGED

A Training Syllabus for Educators

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Counseling the Aged
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COUNSELING THE AGED

A TRAINING SYLLABUS FOR EDUCATORS

Special Training Project on Counseling the Aged
American Personnel and Guidance Association

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To

E. L. Tolbert

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FOREWORD

Robert N. Butler

Director, National Institute on Aging

The American Personnel and Guidance Association has made a significant advance in the field of counseling by providing training materials for working with the aged. Until recently, most counselor education training programs did not address the needs of the elderly. The development and dissemination of these training materials will do much to overcome this deficiency and, more important, provide a model for improving the quality of training of counselors who work with the aged.

Old age is a period of many changes in physiological, behavioral, and social status. These changes often occur rapidly and may have profound immediate as well as long-term effects upon children and grandchildren. The complexity and profundity of aging is one of the reasons that gerontology is such an exciting and challenging area for research. Our lack of understanding of the aging process and society's lack of preparation for the growing numbers of elderly has led many service providers, including counselors, to avoid working with the aged because their problems appear so overwhelming. This sense of futility is augmented by ageism, an individual and societal fear of growing older that is expressed in stereotypes and prejudice against the elderly in many areas, including employment and the availability of services. The APGA's effort to confront the issues of aging augurs well for an improvement in the elderly's self-image and in society's attitudes toward the old.

The Model Training Syllabus is comprehensive and recognizes the need for special attention to the postretirement period. Preretirement counseling has value, but it must be supplemented by retirement counseling services for those who have already retired. Special consideration is also given in the syllabus to the unique problems of minorities, to group as well as individual counseling, and to various social and health policies that affect older people.

The contributors to this project include some of the most experienced people in the field of counseling. I am delighted to see the APGA take leadership in focusing this collective expertise on the needs and problems of the aged. This effort should point up the facts that the aged need to have counseling services available to them, that one can benefit from counseling regardless of age, and that more qualified counselors are needed to work with older people.

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INTRODUCTION

Older people historically have not received and still do not receive their fair share of counseling, mental health, and social services. For example, only 4 percent of people seen in community mental health clinics are 65 and over (Cohen 1977). The term "reluctant therapist" coined by psychologist Robert Kastenbaum in 1964 continues to portray most service providers in that they have devoted little attention to the psychological, social, and basic life-coping needs of the elderly. Operating under the "YAVIS syndrome"(Schofield 1974), mental health workers have spent their energies on the young, attractive, verbal, intelligent, and successful; a rather elite group that by design excludes the older person. Most counselors have traditionally offered their services in the school setting—the population of which seldom includes the older person.

Despite more recent and deliberate efforts of counselors to extend services to increasingly diverse subgroups, including the incarcerated, the handicapped, minorities, and women, and to train for and secure employment in nontraditional settings, counselors still have a disproportionately low number of older people among their clientele. To use terms from Module I, whether this situation arises from "benign neglect" or "overt discrimination" (p. 3), the result is the same: the counseling services available to the elderly are in no way as great as their needs.

The practitioner's lack of involvement with the elderly has been attributed to various obstacles, many of which reflect the ageist values of society. Among these obstacles is the belief that working with the elderly is an inefficient use of time because they are destined to "senility," they are resistant or unable to change, or they are likely to die soon and time is better spent on younger people who can make more substantial contributions to society.

Further, many professionals may be personally uncomfortable working with older people. Counseling the elderly may constantly remind the helping agent that s/he, too, is aging and will someday die. A counselor who has not resolved his/her own fears about the aging process obviously will not be able to provide the quality of services and atmosphere necessary for client growth to take place. When counselors' attitudes and fears about aging even partially impede the older person's realization of his/her capacity for growth, the irony is that the facilitators themselves become obstacles. Counselors need to examine their own feelings, identify their biases, and come to terms with their fears about aging. As Module VII stresses, an initial and crucial step for anyone preparing to be a counselor of older people is to "know thyself."

Contributing to the practicing counselor's lack of involvement with the elderly is the almost total absence of gerontology in the curriculum of counselor education programs. Until very recently, few preservice training programs in counselor education offered students classroom or practical experience in counseling the elderly: A 1975 national survey (Salisbury 1975) revealed that only 18 out of 304 (about 6%) counselor education training programs even offered elective courses in counseling the elderly. Similar deficiencies are apparent in the National Directory of Educational Programs in Gerontology (Association for Gerontology in Higher Education 1976). A practitioner whose academic training included little or no experience with old people is unlikely to direct his/her professional efforts toward this population. The dearth of aging-related instruction conveys to students a subtle but more detrimental message: that the period of older adulthood is of little importance. This continued exclusion mirrors and perpetuates society's values that relegate the older population to an ignoble status.

Paralleling the reluctance of the practitioner and the educator to deal with the elderly is the reluctance of the older client. Most of today's older people do not actively seek counseling and mental health services. A number of reasons may explain this. During the formative years, individuals develop a basic value system, internalizing the values of the society. When the values of today's elderly were being formed, engaging in counseling or therapy was viewed by society with disapproval in contrast to more recent times when obtaining such professional assistance is viewed more favorably as a normal response to a problem. From this historical perspective, it is not surprising that few older people seek professional assistance for personal or interpersonal concerns.

Older people may also hold the culturally conditioned belief that they should be mature enough to handle their own problems without counseling; that they would be considered by others as less capable or independent if they engage in counseling; and that by accepting counseling assistance, they might be taking the initial step on the road to institutionalization. Additional and more concrete deterrents include the cost of therapy and the lack of access via inexpensive and convenient transportation. Furthermore, older people may be unaware of the existence and array of available psychosocial services, particularly counseling. Since the early 1900s, the counseling profession has grown from providing primarily academic and vocational services to providing a variety of therapeutic services of a more psychosocial nature in a variety of nonschool settings. If older persons are not aware of these developments, they cannot be expected to seek the assistance of a counselor for personal and interpersonal concerns.

Given this triad of the "reluctant therapist" (Kastenbaum 1964), the reluctant educator, and the reluctant client, it is not surprising that older people do not receive their fair share of counseling and mental health services. At the same time, older people are subjected to far more than their fair share of life challenges that threaten their sense of well-being and adaptation. Throughout this syllabus the reader is reminded that old age, like other periods, is a developmental stage of life with tasks to master, skills to acquire, and transitions to make. In this sense little difference exists between old age and any other age as all involve development and adjustment. In sharp contrast with earlier life periods, however, the latter stages of life involve numerous adjustments to losses.

Although people of all ages experience losses, during the last stage of the life cycle, losses are ubiquitous and become particularly difficult when experienced simultaneously or in rapid succession. "Losses in every aspect of late life compel the elderly to expend enormous amounts of physical and emotional energy in grieving and resolving grief, adapting to the changes that result from loss, and recovering from the stresses inherent in these processes." (Butler & Lewis 1973, p. 29). An older individual may be forced to adjust to loss of work, income, status, choice, designated and valued roles, social contacts, participation in society, home, physical health, mobility, spouse, loved ones, and friends. Any of these losses experienced individually are difficult; encountered in multiples as they frequently are, they stress one's ability to adapt and compound the normal difficulties of daily living.

Given this array of real and potential losses and crises, the need for the counselor with specialized training in working with the elderly is clear. Contrary to stereotypical belief, research indicates that older people do benefit from effective, timely, and even modest counseling and psychotherapy, that they have an enourmous capacity for change, and that the presence of a confidant in the life of an older person helps mitigate against the negative effects of transitions such as retirement or widowhood (Lowenthal & Haven 1968).

Many of the roles a "gerocounselor" (Module X) will need to assume and many of the functions s/he will need to perform may seem at variance with those traditionally characteristic of the counselor. But many of the older people the counselor will see are suffering not from "intra-psychic" difficulties, but from real problems of daily living. Sixteen percent of the elderly, for example, live below the poverty level (DHEW 1977); 30 percent live in substandard housing (Dovell & Van Horenbeck 1978), and less than 28 percent of the elderly who are eligible for food stamps are receiving them (Butler 1975). A person who is hungry, no doubt, has little immediate concern for self-actualization. No counselor, no matter how skilled, can hope to eliminate depression or anxiety without also helping to resolve some of these debilitating conditions that may contribute to or cause depression or anxiety.

Counseling with the elderly, however, must not be limited to crisis- or problem-oriented interventions, but should emphasize preventive and developmental strategies as well. The opportunities for counselors to assist older people to make positive goal-oriented plans for the future are great, particularly in view of the increasing life expectancy and earlier retirement trends. Within a developmental and preventive counseling context older people and future generations of older people can more realistically look forward to rich and fulfilling later years.

The potential for all counselors, even those who work with the very young, to directly or indirectly assist older people should not be overlooked nor underemphasized. Promoting positive attitudes about aging, introducing gerontology in public school curricula, encouraging lifetime planning, helping people to establish healthy coping skills and to adjust to change are among the many ways counselors who work with people of any age can meet their challenge of promoting the development of today's and tomorrow's elderly.

Who are the elderly?

To design training materials directed at a particular subgroup, the parameters of that subgroup need to be identified. Recently, there has been much controversy among specialists in aging as they attempt to adequately identify the elderly. Even in Federal legislation, old age is not clearly defined and has begun at 55 (CETA), 60 (the Older Americans Act), and 65 (Social Security and Medicare). Of late, gerontologists have been rejecting a strictly chronological definition of old age, arguing that factors other than birthdays are more salient in the determination of an individual as old. Such factors include but are not limited to measures of physical functioning, employment status, life tasks or adjustments, and self-perception, as well as the interaction of these and other variables. Increasingly prevalent in the vocabulary of gerontologists are terms such as young-old, middle-old, and old-old, used to make finer delineations within the older population.

Despite the variety of opinions and the minimal consensus on the definition of the term aged, some mention needs to be made regarding the people about whom this syllabus is written as it would be clearly inappropriate to develop training materials about an unidentified population. Although it is impossible that any one definition of the elderly will be acceptable to all counselors, no less persons in other disciplines or the elderly themselves, the following concepts should help to identify the population about whom this syllabus is written and provide a backdrop for the use of these training materials. The interaction of the concepts of developmental transitions and chronological age seems to present one viable paradigm that counselors can employ to identify the elderly. Accordingly, the population representing the focus of these training materials are those who are experiencing, in large part, the developmental transitions that are more characteristic of old age than of any other period, and are over 60 years old.

Although it seems worthwhile to identify parameters that lend direction to study, training, and practice, exceptions must be made to accommodate individual differences and societal and cohort changes. The trend toward early retirement, for example, may lower this figure while the recently passed legislation banning most mandatory retirement might have reverse effects. Furthermore, because of poor health and socioeconomic conditions, many minority elderly do not reach their 60th birthday, and may experience "old age" at a much younger chronological age. Any definition of the elderly is only useful for the aggregate, not for any one individual.

The Modules: An Overview

The knowledge and skills counselors acquire to work with the general population apply to the older population. The counselor of the older adult first needs general training in the basics of counseling including but not limited to training in principles of guidance and counseling, theories of personality and development, counseling techniques, consultation procedures, group counseling, tests and measurements, career development, research, and so on. These and similar courses representing the core of counseling are already part of counselor education programs and are not the focus of this syllabus. The materials provided here are not a substitute for but a complement to the core curriculum and provide information and guidelines for the educational experiences of those training to become counselors of older people.

When preparing to be a counselor of the elderly, the student needs a cognitive understanding of the demography and dynamics that make old age different from other developmental periods. Modules I through V provide an overview of this kind of information: demographic characteristics of the older population that have particular relevance to counselors are covered in Module I, and the developmental transitions of old age are introduced in Module II and addressed in greater detail in Modules V-B and V-C.

Interplay between physical and mental health is significant, and older adults experience numerous physical changes that require important adjustments. The counselor of older people, in contrast to the counselor of younger people, needs a greater understanding of the normal and abnormal physiological changes of his/her client (Module III).

Few theories of counseling or personality address the older person. Yet, effective counseling must be guided by a theoretical framework that permits mediated and orderly intervention and precludes trial and error or random counselor responses. Module IV presents an overview of the psychosocial theories of aging.

Because old age is characterized by multiple transitions, a theoretical perspective of the nature of transitions is provided in Module V-A. This model should enable the reader to better understand the transitions which are frequently encountered in old age subsequently discussed in Modules V-B and V-C.

It is important for the counselor to understand the unique cultural differences of elderly minorities and become sensitive to the compounded difficulties an older minority member may experience. Four minority groups have been represented in Module VI. Clearly, other groups warrant particular attention as well. Depending on the geographic region or the composition of the community, the professor and student may want to select other groups for study.

The first six modules provide information about later life that a student needs when preparing to be a counselor of older people. Once mastered, the student must be able to translate this information into action. Module VII suggests how basic counseling skills can be delivered in a manner consonant with the particular needs and values of the older population.

Older people themselves can be invaluable in the delivery of counseling services. Module VIII provides suggestions for the development of counseling programs using peer and paraprofessional counselors. Specific guidelines are included for selection, training, and evaluation of peer counselors.

Because most older people are unlikely to seek counseling assistance and because many counseling settings are inaccessible to the older person, counselors must extend their services to nontraditional settings. Module IX proposes such environments for the provision of counseling services. Guidelines for supervised practical experiences, a must for all counselors, are provided in Module X.

An important aspect of good counseling for the elderly is being aware of and developing an expertise in the procurement of available social services that can have a positive impact on stress-producing life problems. Further, as an advocate, the counselor must try to eliminate, through legislative means, some of the oppressive external conditions impinging on the lives of older people. Module XI provides an expanse of information regarding policy, issues, and the network in aging.

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Mary L. Ganikos

This poem was found among the few simple belongings of an elderly lady after she died in a geriatric ward of a hospital.

What Do You See?
What Do You See?

What do you see nurses, what do
You see?
Are you thinking when you are
Looking at me—
A crabbit old woman, not very
Wise,
Uncertain of Habit, with far-away
eyes.
Who dribbles her food and makes
No reply
When you say in a loud voice—
"I do wish you'd try."
Who seems not to notice the
Things that you do,
And forever is losing a stocking
Or a shoe.
Who unresisting or not, lets you
Do as you will,
With bathing and feeding, the long
day to fill.
Is that what you are thinking—
Is that what you see?
Then open your eyes, nurse, you're
Not looking at me.
I'll tell you who I am as I sit
Here so still;
As I use at your bidding, as I eat
At your will,
I'm a small child of ten with a
Father and mother,
Brothers and sisters, who love one
Another.
A young girl of sixteen with wings
On her feet,
Dreaming that soon now a lover
She'll meet;
A bride soon at twenty — my heart
Gives a leap,
Remembering the vows that I
Promised to keep;
At twenty-five now I have young
Of my own,
Who need me to build a secure,
Happy home;
A woman of thirty, my young now
Grow fast,
Bound to each other with ties that
Should last;
At forty, my young sons have
Grown and are gone,
But my man's beside me to see
I don't mourn.
At fifty, once more babies play
Round my knee.
Again we know children, my loved
One and me.
Dark days are upon me, my
Husband is dead,
I look at the future, I shudder
With dread,
For my young are all rearing
Young of their own,
And I think of the years and the
Love that I've known.
I'm an old woman now and nature
Is cruel—
Tis her jest to make old age look
Like a fool.
The body it crumbles, grace and
Vigour depart
There is now a stone where I once
Had a heart;
But inside this old carcass a young
Girl still dwells.
And now and again my battered
Heart swells.
I remember the joys, I remember
The pain,
And I'm loving and living life
Over again.
I think of the years all too few—
Gone too fast,
And accept the stark fact that

Nothing can last,

So open your eyes, nurses, open
And see
Not a crabbit old woman, look
Closer — see Me!

USER'S GUIDE

In the preparation of this training syllabus, it was recognized that curricula related to counseling the older adult are at varying stages of development among institutions of higher education. Likewise the structures and focal points of preservice counseling programs are highly diversified. It is unlikely that one training syllabus could be designed such that it could be similarly employed by the numerous institutions and training programs. It was, therefore, the intent of the staff throughout the development of this syllabus to generate a product that would be flexible enough to be used by differing institutions and for a variety of functions. Although there are many possible ways in which the user might employ this syllabus, some suggestions follow:

- for use in its entirety as one course on counseling older adults
- for use as separate courses in counseling or gerontology curricula
- for inclusion in, or supplementation of, existing courses
- for use as a model in the development of curricula related to gerontological counseling
- for preparation of in-service training materials and staff development programs
- for development of special presentations, seminars, or workshops.

While it is necessary to impart content, the objective in the preparation of this syllabus was not to create a detailed text as there are numerous textbooks available for both counseling and gerontology. Rather, the materials were designed to provide an expanse of basic information about aging, placing major emphasis on those aspects particularly relevant to counselors. This objective is reflected in the module structure as it is intended as a compromise between a textbook and a lesson plan. Most modules include counseling implications and strategies, concrete classroom activities, and suggested modes of assessment that an instructor can readily adapt for training purposes. This approach is not to minimize the necessity of a thorough knowledge base of the field of aging but is an effort to provide increased information regarding teaching methodology and therapeutic strategies in gerontological counseling. Supplemental references have been provided in each section. It is hoped that the syllabus will serve as a starting point for educators to train counselors in the field of aging and that it will be continually supplemented as new materials related to counseling the aging become available.

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MODULE I

DEMOGRAPHIC ASPECTS OF AGING: IMPLICATIONS FOR COUNSELING

Richard Blake
David Peterson

Rich Blake received his Ed.D. degree from the University of Missouri—Columbia in 1966 and joined the faculty of Omaha University (now the University of Nebraska at Omaha) that same year. Since 1974 he has served as the coordinator for the master's degree program in counseling with specialization in gerontology.

He has written professional articles on counseling and aging and has served as workshop presenter, speaker, and consultant to numerous groups and programs that work with older persons. He has worked extensively with the Area Agency on Aging in his community and is presently chairperson of the area Advisory Council for the Senior Companion Program. He has been an active member of APGA's Committee on Adult Development and Aging for several years and is currently immediate past-president of Nebraska Personnel and Guidance Association.

David Peterson received his doctorate in adult education from the University of Michigan. His involvement in gerontology began in 1968 when he joined the staff of the Institute of Gerontology at the University of Michigan where he directed the graduate training program of the institute and established the doctoral program in educational gerontology within the school of education.

From 1972 through September 1978, he directed the gerontology program at the University of Nebraska at Omaha. His teaching experience has been in education and social policy for the aging. He is presently Director of the Leonard Davis School of Gerontology at the Andrus Gerontology Center of the University of Southern California.

DEMOGRAPHIC ASPECTS OF AGING: IMPLICATIONS FOR COUNSELORS

Rationale and Objectives

In the last two decades we have seen and been part of an increased awareness of unmet human needs and rights. Attention has focused on those whose potentialities and expectations have gone unfulfilled, sometimes as a result of benign neglect, sometimes as a result of overt discrimination. A broad movement to correct past wrongs has touched the lives of many persons, even if it has not yet re-created our society as what we would like it to be.

This apparent search for special groups that need and deserve special attention is turning toward our older citizens, and for good reason. The aged are one group that includes individuals of immediate, personal significance to most of us. They are one minority group that cuts across all other elements of our society, racial, economic, educational, geographic, political, and sexual (including both sexes and even those without clear sexual identity). The old are one minority group to which we can all aspire. Old people have been victimized by both neglect and overt abuse.

Demographic facts about our older population are presented in this unit, and implications of those facts are discussed. The demographics of aging are important because they are the basis for an accurate understanding of general population trends, which are the basis for social planning. We need demographic data in order to identify needs and plan for service delivery. Knowledge of demographic facts can also dispel some of our wrong ideas about aging and help us to dispel mistaken and potentially harmful beliefs of others, including older people themselves.

The objectives of this module are as follows:

(1) To present relevant demographic data about the elderly population and the implications that the data have for counselors.

(2) To provide counselors with sufficient information to enable them to present demographic facts about the older population to others.

(3) To assist counselors in recognizing the relationship between demographics, services, and possible counselor functions.

Content

DEMOGRAPHY OF AGING

Demography is the study of the changes in population distributions. Its purpose is the understanding and projection of the dynamic population elements of the world, the nations, and subnational units. In general, demography deals with the macro-level perspective, that is, with large groups. Typically, the data are not particularly accurate in reflecting the condition of any specific person but are a composite of all individuals in a category. Demography, then, portrays a generalized view of the population, a foundation upon which any analysis of the situation can occur, and a basis for projection into the future.

The counseling field has concerned itself with demography for a long time but not with special focus on the older population or the aging trends of the general population. In the past, most attention was placed on the size and demographic trends of student populations, the work force, employment and unemployment rates, and other detailed aspects of work force composition. When retirement rates were studied, it was usually because of their relationship to new job openings — entry opportunities for young workers — rather than because of specific concern with those retiring or implications of the data for services to older persons themselves. As a service profession and field of study, counseling needs to concern itself with the demography of aging and its implications for our society generally, and for counseling in particular. Appropriate use of any demographic data, however, requires an understanding of certain basic concepts and facts about demography.

BASIC CONCEPTS OF DEMOGRAPHY

Demographic study is based on three concepts: fertility, mortality, and migration.

Fertility

Fertility is a measure of the birthrate for any given period of time. Since the birthrate varies from one year to the next, the number of people in various categories differ. For example, many people were born between 1945 and 1960; so that group is large. The birthrate established the size of that population group for the length of its existence. By applying the mortality rates to persons born within certain periods, it is possible to be reasonably accurate in describing the size and composition of the older population in the future, at least for the next 65 years.

Mortality

Mortality is the description of the death rates which currently apply to the population or its subparts. These rates have changed for persons in different age groups over the past years and probably will continue to do so in the future. It is difficult or impossible, however, to anticipate how much these rates will change for specific groups in the population. So it is typical to make projections based on the current death rates. By use of this approach, it is possible to project with some accuracy the size of the different age groups in the future and to estimate how many people will be in the older age categories at any point in time.

Migration

Migration is the final demographic variable which can affect the size and composition of a population. It is common knowledge that in the late 1800s and the early 1900s millions of immigrants entered the United States and therefore changed its population composition. Since most of them were young people, this migration had the effect of making the total population younger. Immigration has generally stopped now, with approximately 400,000 persons entering the country annually (Cutler & Harootyan 1975). This number is low enough that demographers typically disregard the effect of migration on the nation as a whole. This trend possibly could change in the future, but since there is little indication that it will change, the best projections generally ignore the effect of migration.

CONSIDERATIONS IN USING DEMOGRAPHIC DATA

Demographers have been careful to develop clear and precise definitions for the terms they use, since a variation in definitions can make a tremendous difference in the results that are described. For example, if the "older population" is composed of persons 60 years of age and older, there are currently 31,643,000 persons in that category, or 15 percent of the total American population. On the other hand, if only those age 75 and over are included, there would be only 8,527,000 persons or 4 percent of the population (Siegel 1976). The definition becomes important because both of the figures are accurate (but neither is the generally accepted size of the current older population).

Demographic data can never be completely accurate because changes are always occurring in the population. It is impossible to measure everything all the time, so while reading about demography, the reader should continuously be asking: "Where did those data come from?" and "How recent are they?"

Demographers generate data in several ways. The first and most expensive is to ask every person questions that will provide the necessary information. This is done every 10 years in the national census. A massive undertaking, the census attempts to survey every individual in the nation to discover his age, sex, residence, income, and occupation, among other things. It is the best source of data, since it supposedly collects information from everyone. Of course, there are errors even in the census because some people are missed, some people do not tell the truth, and some people do not understand the questions and give inaccurate answers.

A second method of data collection is to sample the population. By generalizing from a sample it is possible to provide an accurate representation of the whole population. Sampling is often done and generally provides good data, except when the sample is not representative of the whole population. In that case, the data will not be as accurate as one would like. Again, it is possible that some people who are sampled may not answer the questions honestly or accurately.

A third means of gathering data is through current records of births, deaths, property owned, and marriage licenses issued. Records provide a major source of data that is relatively easy to obtain and much less expensive than interviewing thousands of persons. This information, too, may be inaccurate. It may be incomplete or missing in the area of interest to the demographer. It may be inaccurately recorded or lost. It may differ from one geographic area to another. But it is still a very valuable source of information.

Even though there may be errors, the census, sampling, and records are the best methods available for collecting data on the population. It is important to know when the information was obtained. For example, if a particular fact is published in a book with a copyright date of 1974, the reader may assume that the information is quite recent. However, the author may have written the book in 1972. S/he may have preferred to use census data but found that the 1970 census figures were not available at that time, so s/he would have used the 1960 data. Thus a book read in 1978 may easily give the reader data that are 18 years old — quite unacceptable in many cases.

Demographic categories should be carefully distinguished, too. They may be either real or artificial. For instance, the "number of persons in the United States" is a real category, encompassing a group of persons who actually exist within the boundaries of the country. On the other hand, "the older population" is an artificial category. Persons are included in it if they are 65 years or older. The age of 65 is an arbitrary point; a person does not magically change at 65. Some may be retired, others not; some may be healthy and active, others just the opposite; some may be respected, involved citizens, while others may have completely disengaged and are only waiting for death. They may have very little in common other than having had at least 65 birthdays. One must be careful not to think of them as a real group, but as a statistical category established merely for the convenience of presenting the data.

SIZE OF THE OLDER POPULATION

The older population is generally defined to consist of those persons who are 65 years of age or older. In 1975, this category included 22.4 million individuals and was estimated to be growing by approximately 460,000 persons per year. This group currently comprises approximately 10.5 percent of the U.S. population. The estimate of both the older population and of the total U.S. population is provided by the U.S. Bureau of Census, Current Population Reports (Siegel 1976). These figures are updated regularly and are based on sample surveys taken between the decennial censuses.

The older population has experienced sustained growth during this century. In 1900, it included 3.1 million persons, or 4.1 percent of the total population. It has steadily increased through the first three quarters of this century and is expected to continue that growth in the future. The number of older persons will probably peak at approximately fifty-two million in the year 2030 and will decline slightly from that point (Siegel 1976).

Graph 1 shows how this population change has occurred. The growth has been steady during this century and will continue to be so until after 2010 when the rate of increase will accelerate. The acceleration will occur because the post-World War II babies will reach old age at that time. The group will expand the older population for a time, but eventually the bulge will be reduced as smaller, subsequent age cohorts reach age 65.

When examining the relative size of the older population the major variable is the size of the rest of the population. The number of older persons has increased more rapidly than other segments of the population during each decade of this century and is expected to continue to do so until 1990. The rate of increase could be accelerated if fertility remains at its current low level. If so, there would be fewer young people, and the older population would constitute a greater percentage of the total population. If the fertility rate increases, the opposite will occur.

Various assumptions can be made in projecting the relative size of the older population. Assuming that the U.S. will maintain a birthrate of approximately 2.1 children per female (a zero growth rate), the older population can be expected to comprise 11.6 percent of the population by the year 2000 and 13 percent by 2020. If the fertility rate is substantially higher, say 3.1 children per female, the relative size of the older population will be substantially smaller, approximately 8.9 percent in the year 2000 and 9.1 percent in 2020 (Siegel 1976). Graph 2 shows the possible range of percentages for the period 1980-2050.

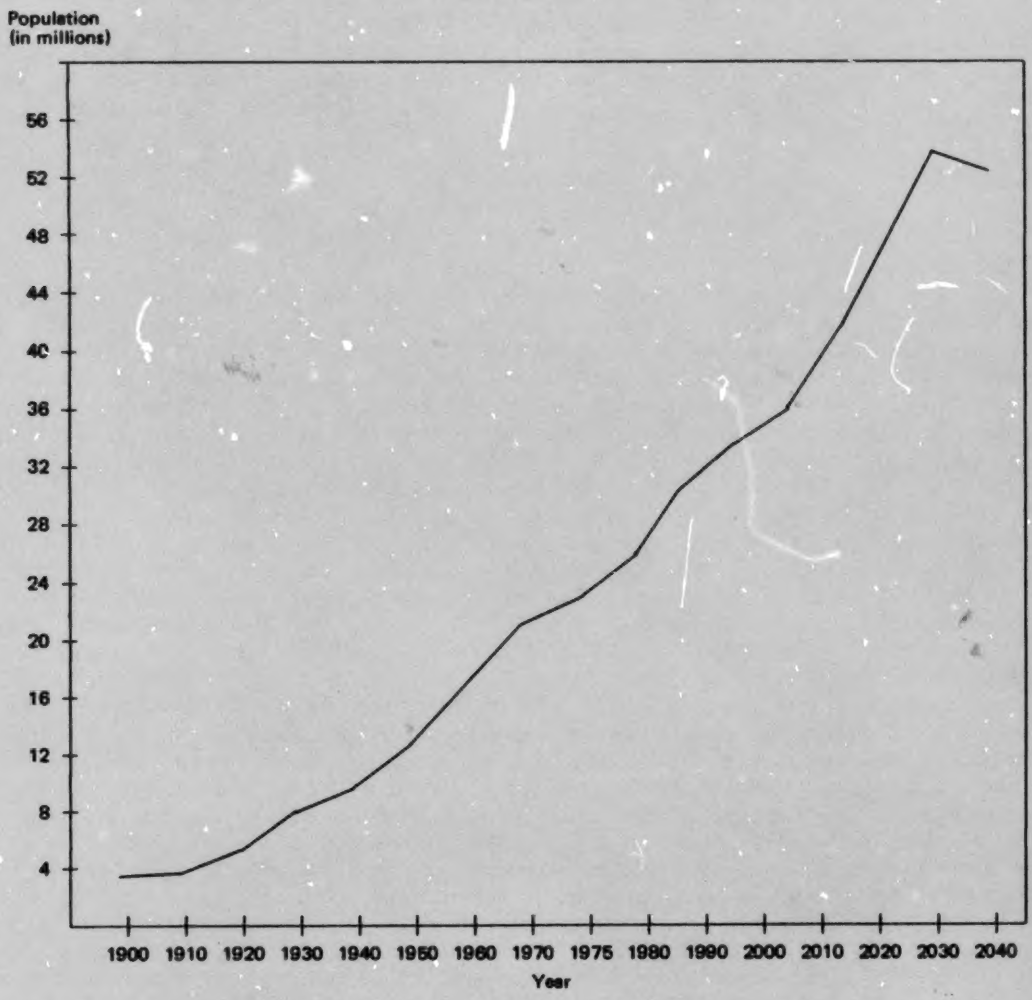
The relative size of the older population is especially important in the allocation of resources among the various segments of the population. As the older population increases, its members may be expected to demand an increasing proportion of the goods and services of the nation. These will accrue through government programs such as Social Security, through the provision of private pension benefits from employers, and through possible direct-service programs, such as nutrition sites and meals on wheels.

In absolute numbers and relative size, the older population is increasingly significant as a potential clientele. Even the number of older persons is not an adequate representation of the potential, because work with older persons may also involve family members and other concerned persons.

Estimates of needed counselors have been made for other populations such as elementary students, and various counselor-client ratios have been advocated for such groups, but these are not an adequate precedent for establishing counselor need for older persons. Hitchcock (1965) suggested that 10 percent of those in the labor force between the ages of 22 and 44 needed counseling, that 25 percent of those age 45 years and older needed counseling, and that those with handicaps would be even

GRAPH 1

Size of the Older Population (65+)

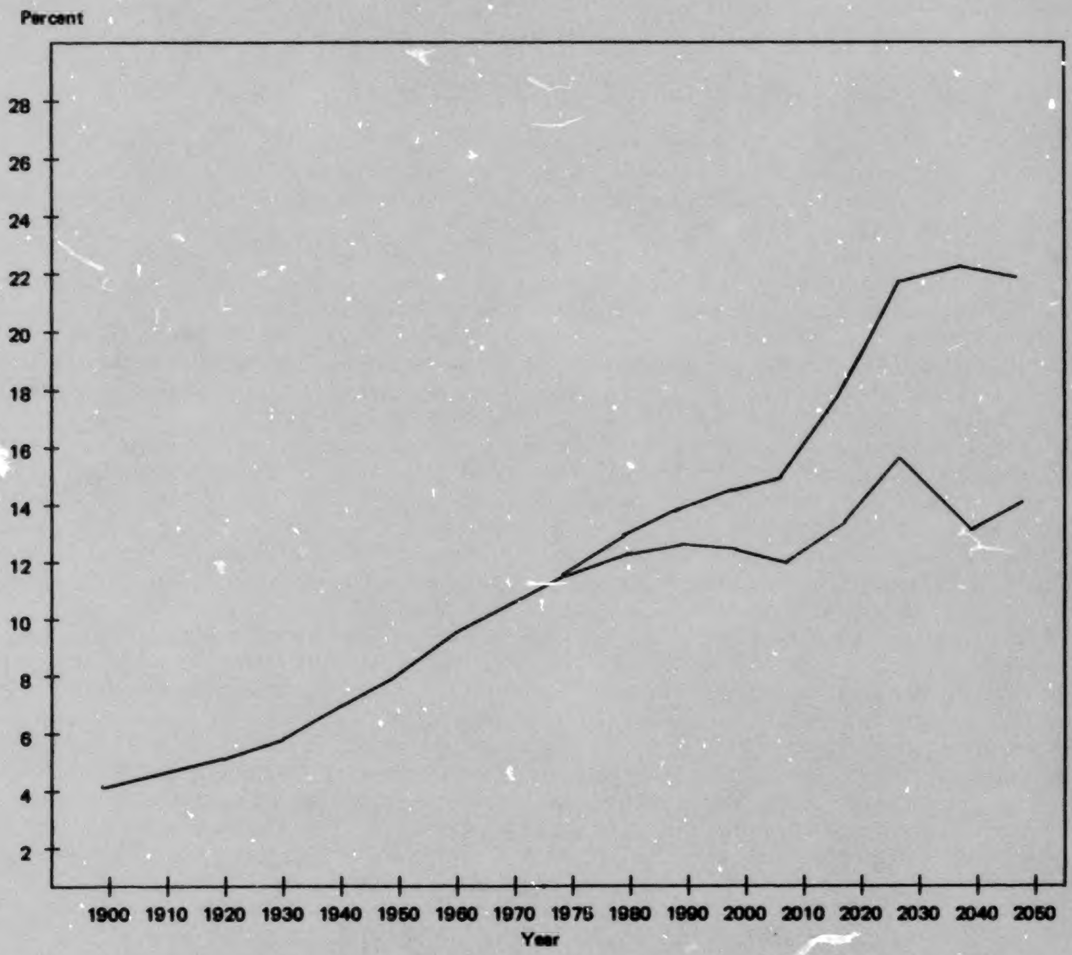


Year	Population	Year	Population
1900	3,099,000	1975	22,400,000
1910	3,986,000	1980	24,523,000
1920	4,929,000	1990	28,933,000
1930	6,705,000	2000	30,600,000
1940	9,031,000	2010	33,239,000
1950	12,397,000	2020	42,791,000
1960	16,675,000	2030	51,590,000
1970	20,085,000	2040	50,266,000

Source: Siegel, Jacob. *Demographic Aspects of Aging and the Older Population in the United States.*

GRAPH 2

Percent of the U.S. Population (65+)



			Percent Range		
Year	Percent	Year	2.7 Children/ Women		1.7 Children/ Women
1900	4.1	1980	10.9	–	11.1
1910	4.3	1990	11.1	–	12.2
1920	4.6	2000	10.7	–	12.5
1930	5.4	2010	10.3	–	13.3
1940	6.8	2020	11.8	–	17.0
1950	8.1	2030	12.8	–	20.9
1960	9.2	2040	11.0	–	21.1
1970	9.8	2050	11.3	–	20.7
1975	10.5				

Source: Siegel, Jacob S. *Demographic Aspects of Aging and the Older Population of the United States.*

more likely to need counseling. His idea that the need for counseling increased with age is probably right, but it is of little help in projecting numbers.

Even aside from new counselors in possible new programs, the numbers of older persons in combination with changing laws and attitudes suggest that existing programs such as the employment service and vocational rehabilitation should prepare for an aging clientele.

The counselor services that will be provided to older persons depend only in part on demographics. Political, economic, and social considerations will also be determining factors as will the roles of others such as social workers and recreation specialists. The willingness and ability of counselors to relate their skills to the needs of older persons and to influence political and social factors could affect how the potential represented by demographics changes to a reality in services.

GEOGRAPHIC DISTRIBUTION OF THE OLDER POPULATION

The older population is distributed across the United States in a pattern similar to the rest of the population. More than one-half of the older people live in 10 large states, whereas 20 small states have only 10 percent of the older population. New York and California each have more than 2 million older persons, whereas Alaska is estimated to have only 8,000 persons over age 65 (Cutler & Harootyan 1975).

The percentage of older people in the states varies somewhat. Alaska has the lowest proportion, with only 2.6 percent over 65. Florida has the highest proportion, with 15.8 percent over the age of 65. The other states fall between 6.7 percent (Hawaii) and 13 percent (Brotman 1976). Seven states are in the high range between 12 and 13 percent: Arkansas, Iowa, Kansas, Nebraska, Missouri, South Dakota, and Oklahoma. These states have a high proportion of older people because of the continuing out-migration of their younger populations (Brotman 1976).

Another factor to consider is the percentage increases of older people in the various states. From 1970 to 1974, four states increased their older population by 20 percent or more. Nevada (34 percent), Arizona (30 percent), Florida (28 percent), and New Mexico (22 percent) have grown primarily because of the migration of older persons from northern states to more temperate regions. Nevertheless, only Florida has really experienced a large number of older migrants; the other states have added a number of in-migrants to the small state population; so the percentage increase is large, but the total number of persons involved is small (Brotman 1976).

Although migration has greatly affected Florida and to a lesser extent other southern and western states, it is not a major variable in the location of the older population. In any year, only 9 percent of the 65+ population can be expected to change residence. Of that percentage, two-thirds relocate in the same county, one-sixth moves within the state, and only one-sixth moves to another state. Although the overall distribution of older people in the nation is not likely to change substantially, some areas may have significant adjustments to make. Arizona, California, and Florida are already feeling the strain on their health and social service delivery systems of the increased number of older persons. In some areas, thirty to forty percent of the population is over 65 and is placing a heavy demand on the current services. Questions are being asked about the advisability of building new retirement communities or encouraging more older people to locate in them.

Most older people live in cities. The Bureau of Census reports that 64 percent of those age 65 and over lives in metropolitan areas. Of the total older population, 34 percent lives in the central city and 30 percent lives in metropolitan areas outside the central city. Sixteen percent of the 65+ population lives in small towns, 4 percent on farms, and 16 percent in rural non-farm areas (Bureau of Census 1976a).

In planning for service delivery systems, including counseling, local population statistics and local trends in in-migration or out-migration need to be considered for their implications of relative emphasis. For example, in areas of heavier out-migration, programs providing assistance in identifying and choosing relocation possibilities might be emphasized, while in areas of in-migration adaptation and orientation support could be emphasized. It should be remembered, however, that older people are like every other group in that they are everywhere, generally stay where they are, but do migrate anywhere. Some older people are even moving into areas of relatively heavy out-migration.

LIFE EXPECTANCY AND AGE COMPOSITION

The life expectancy at birth has increased throughout history. Rather than extending the later years of life, the major increase has occurred because the infectious diseases of childhood — influenza, tuberculosis, pneumonia — have been generally eradicated during this century while those of old age remain. Graph 3 shows the changes in life expectancy that have occurred for persons at birth and at age 65. It should be noted that the increase in life expectancy at birth has been concentrated during the period from 1900 to 1940. Since then, the increase has become much slower. For persons aged 65+, the growth has occurred over the whole century but has been much slower than for younger persons (Cutler & Harootyan 1975).

Future projections for life expectancy generally are not available. As noted earlier, demographers are hesitant to speculate on possible changes in death rates when there is no way to be sure when and if certain developments will occur. Therefore, they typically choose to project the current rates into the future.

If certain maladies could be controlled, an increase in life expectancy would result. For instance, if cancer and stroke were eliminated, life expectancy for the 65-year-old would increase 1.5 years; elimination of heart disease would add 5 years; and control of all cardiovascular-renal diseases would add 10 years to the average life expectancy (Brotman 1976). There is no assurance that all of the permutations of these conditions would be controlled for all persons; so the amount of increase in life expectancy is highly speculative.

While many people are accustomed to thinking of life expectancy only in relation to life expectancy at birth, it is also possible and useful to consider life expectancy for persons of any age. One phenomenon which counselors should guard against and help others keep in mind is that the life expectancy data most often quoted are applicable only to the newborn. When assisting persons 60 years old in making their retirement plans, for example, it is not especially relevant and can be very misleading to consider life expectancy at birth. As Graph 3 and Table 1 indicate, the older we get the older we can expect to get. On the average, persons 60 years old can expect to reach 79 years of age, not 71, which is approximately the life expectancy at birth. This is about a 70 percent difference and one that could substantially affect planning. Counselors should consider life expectancy and mortality rates in relation to those with whom they are working, not just life expectancy at birth.

In addition to expanding, the older population of the United States is growing older; that is, the average age of persons in the 65+ category is increasing. In 1940, the median age of the older population was 71.4 years; by 1970 it had risen to 72.8 years; and by the year 2000, it is expected to reach 73.9 years. This means that the oldest part of the 65+ population has increased faster than the youngest part. Between 1940 and 1970 the 65-to-74 group decreased from 71 to 62 percent; the 75-to-84 group increased from 25 to 30 percent; and the 85+ group doubled from 4 to 8 percent of the older population (Siegel 1976).

The remainder of the century should show a continuation of this trend. By the year 2000, the group 65 to 74 is expected to decline to 56 percent of all older people; the group 75 to 84 should increase to 34 percent; and those 85+ will increase to 10.5 percent (Brotman 1976).

Since infant and childhood mortality rates are already low, future extensions of life expectancy will increasingly be the result of adults living longer. Successes in controlling degenerative diseases will place increasing demands on income maintenance, housing, transportation, and other services. Since the life expectancy of persons 65 is already about 15 years (or to the age of 80), future increases in life expectancy will tend to increase most the oldest portions of the older population. It is the oldest portion of the older population that requires the most, and most expensive, services. The implications of these trends are all toward increased costs. Social Security, private pension plans, and medical insurance will all cost more. The relative costs to society will be particularly great if the years of increased life expectancy are spent outside the labor force, as has been and will apparently continue to be the case.

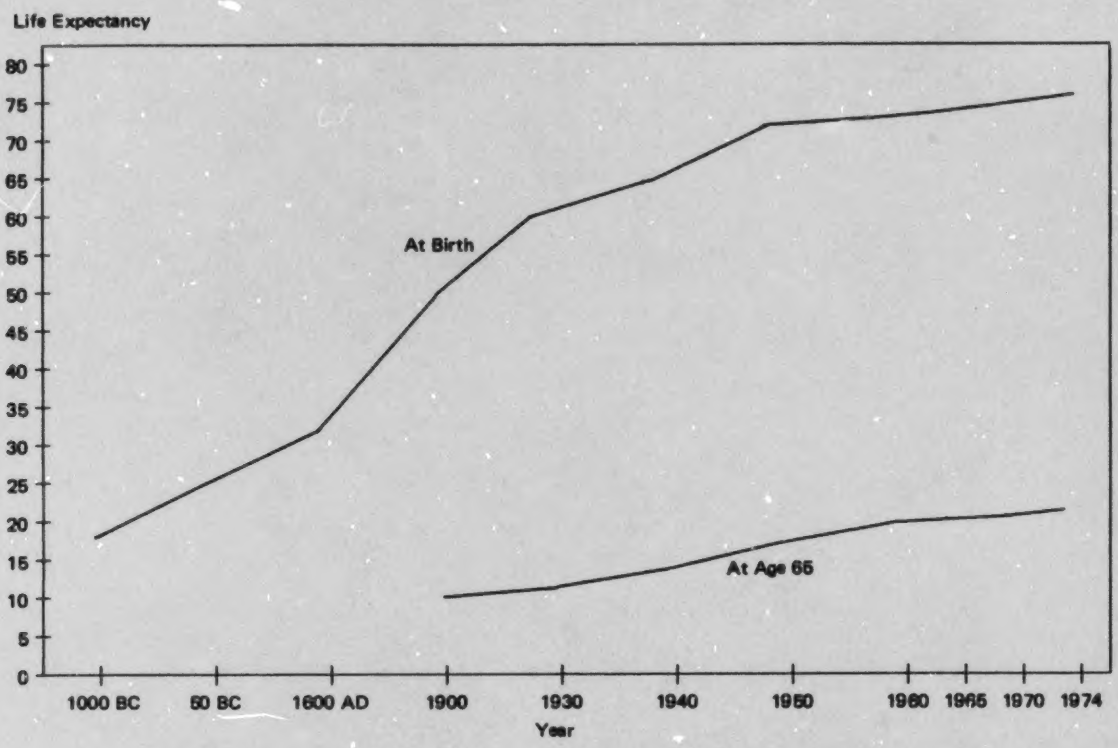
While the services required for the older population are increasingly physical and health oriented, and although some persons may indeed reach a point where they are no longer making decisions or planning for themselves, or may even be unable to communicate, this does not necessarily mean counselors can have no role. It may simply be that as the population ages the role of the counselor tends to shift toward working more with those accepting responsibility for the older person, such as relatives or program administrators and staff. Supportive counseling, resident staff training, and home-delivered services may become more important as the older population continues to age.

LIVING ARRANGEMENTS

Most older people live in the community: slightly more than half with their spouse, more than one-quarter alone, and 15 percent with relatives. The majority of older persons (over 85 percent in most studies) live less than an hour's distance from a child (Binstock & Shanas 1976). Although some people assume that older people are largely confined to nursing homes or homes for the aged, only five percent of the older population lives in any kind of institution. Most older people are able to care for themselves and consequently do not need the support of institutions, but during the course of life many may need some institutional care.

GRAPH 3

Life Expectancy at Birth and at Age 65



	At Birth	At Age 65
1000 BC	18.0	–
50 BC	25.0	–
1600 AD	32.0	–
1900	49.2	11.9
1930	59.3	12.3
1940	63.6	12.8
1950	68.1	13.8
1960	69.9	14.4
1965	70.2	14.6
1970	70.8	15.0
1974	71.9	15.6

Sources: Cutler, Neal E. and Harootyan, R. A., *Demography of the Aged.* Siegel, J. S., *Demographic Aspects of Aging and the Older Population . . .*

TABLE 1

Expectation of Life and Mortality Rates, By Age, Race, and Sex

Age (years)	Expectation of life in years					Mortality rate per 1,000 living at specific age				
	Total	White		Negro and Others		Total	White		Negro and Others	
		Male	Female	Male	Female		Male	Female	Male	Female
Under 1	71.0	68.9	76.0	62.9	71.2	16.75	16.82	12.86	27.28	22.41
1	72.2	69.1	76.0	63.7	71.8	1.00	1.05	.78	1.51	1.30
20	53.9	15.0	58.1	45.7	53.5	1.32	1.85	0.58	2.96	1.02
30	44.6	41.8	48.4	37.4	44.2	1.45	1.86	.75	4.71	1.87
40	35.3	32.6	38.0	29.3	35.3	2.79	3.00	1.75	7.72	4.14
50	26.7	24.0	29.8	22.0	27.1	6.79	8.23	4.29	15.13	8.72
60	19.0	16.5	21.4	16.0	19.0	15.98	20.88	10.02	20.01	17.88
65	15.6	13.4	17.6	13.4	16.7	22.85	31.39	14.49	37.36	21.50
70	12.5	10.6	14.0	11.1	13.7	34.41	46.51	23.04	55.93	39.10
75	9.8	8.3	10.7	9.6	11.8	53.23	70.10	40.11	76.40	53.65
80	7.6	6.4	8.1	8.3	9.9	79.48	103.33	65.96	89.85	62.27
85+	5.7	4.9	6.7	7.8	–	–	–	–	–	–

From: U.S. Bureau of Census. Statistical Abstract of the U.S., 1976 (97th Annual Edition). Washington, D.C.: Dept. of Commerce, 1976.

Recent studies have shown that approximately 25 percent of the older population will spend some time in a nursing home (Palmore 1976; Kastenbaum & Candy 1973). Those under care are likely to be the oldest part of the group; currently 14 percent of the 85+ age group is in a nursing home, while only 2 percent of the 65-69 age group is there. Institutionalization is more likely for those who are unmarried (separated), living alone, female, and white, and for those with no living children (Palmore 1976). Although there has been a recent effort to keep people out of institutions, between 1960 and 1970 the percentage of older people in institutions increased from 3.8 percent to 4.8 percent of the older population, primarily because of increased government payments under Medicaid and Medicare (Palmore 1976).

Most older people (70 percent) living in the community reside in families of only two persons (Cutler & Harootyan 1975). Men are especially likely to be married and living with their spouses. The number of older persons who live with their children has declined in the past decade, resulting in greater independence as well as greater isolation of the older population.

Since the vast majority of older persons live in the community rather than in institutions, they use and are dependent upon the same community services as the general population. YMCA's, churches, service clubs, police departments, bus and cab companies, electric companies, and all the other agencies have older people as clients or customers, if not as employees. Persons working in these agencies are subject to the same misconceptions and biases about aging and older people as the rest of us. If prepared to do so, counselors could be part of a widespread educational effort in agencies to correct erroneous beliefs and alter attitudes toward aging and older people. As indicated previously, traditional counseling services such as marriage counseling centers, employment services, and family services should expect an increasing clientele of older persons who live in the community and who expect to use a wide range of community services.

SEX RATIO AND MARITAL STATUS

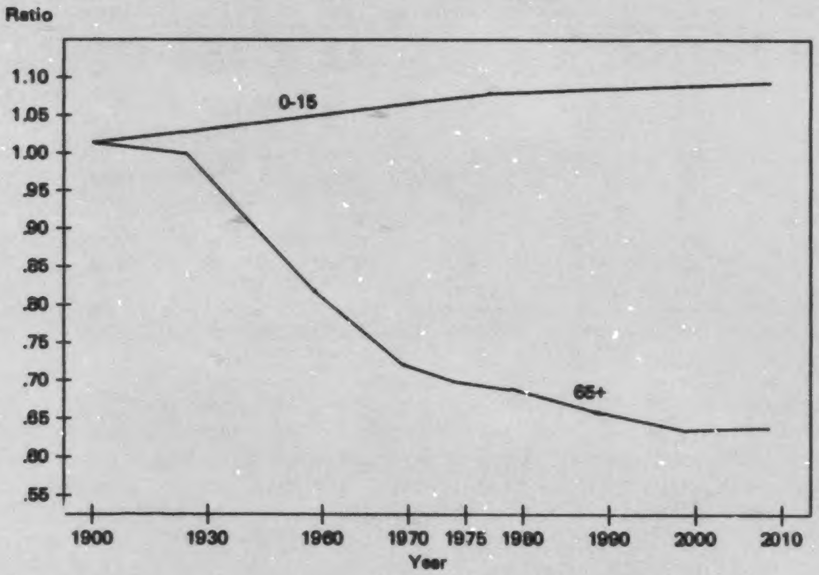
The sex ratio is the number of males per 100 females in the population. Graph 4 shows that from 1900 to 1970, the sex ratio for persons under age 15 has remained constant, with slightly more males than females. The ratio for persons 65+ has declined dramatically and now shows only seventy-two men for every 100 women (Siegel 1976).

Thus, the older the population group, the smaller will be the sex ratio: 79.3 for individuals in the 65-to-69 age range; 65.4 for those 75-79; and 49.5 for those 85+. As the median age of the older population continues to rise, the disproportionate number of women is likely to grow. By age 65, most women are widowed and consequently isolated from the filial, social, psychological, and economic supports which may come from marriage. In 1974, 79 percent of the older men in the United States were married, while only 39 percent of the older women were. Fifty-two percent of the older women were widowed while only 14 percent of the men were widowers (Brotman 1976). This imbalance is aggravated because men in this country tend to marry women who are two to five years younger than themselves. If the wife is five years younger, there is a 75 percent chance of her being widowed (Brotman 1976).

There are about three unmarried women over 65 for every unmarried male. Half of the men over 65 who get married marry women under 65. Older men are much more likely to be married or get married, while older women are more likely to be or become widows.

GRAPH 4

Sex Ratio at Age 0-15 and 65+



	0-15 Years	65+ Years
1900	102.1	102.0
1930	102.8	100.4
1960	103.4	82.6
1970	103.9	72.0
1975	104.1	69.3
1980	104.5	67.9
1990	105.0	66.1
2000	105.2	64.9
2010	105.2	65.5

Source: Siegel, J. S., *Demographic Aspects of Aging and the Older Population in the United States.*

The greater number of older women and their greater likelihood of living alone indicate a greater need for services aimed at women. Even so, there are still substantial numbers of older men whose life roles outside the home and whose relatively worse health make life alone at least as difficult as for older women. Perhaps the needs of older women are better recognized and met than those of older men.

EMPLOYMENT AND FINANCES

Most older people are retired. We have come to think of this as the normal state of affairs, but only in this century has retirement become common. Over two-thirds of men 65+ were still employed in 1900; their number had dropped to 46 percent by 1950; and less than 25 percent are in the labor force today (Brotman 1976). Women over the age of 65 have never been common in the labor force. Since 1900, the percentage of older working women has increased from 8 to 10 percent.

Forty-four percent of the older workers are employed part time; twenty-nine percent are self-employed (Brotman & Williams 1971). Retirement has become so pervasive that an older person has difficulty finding a job unless s/he is self-employed in business or a profession. Despite some attempts to modify the compulsory retirement system operating in many sectors of the economy, change has been slow, and the future is likely to see most older people living outside the work force.

The increased leisure and lessened structure in daily living, increased awareness of or lack of purpose, disassociation from former colleagues and friends, and altered identity and self-concept often associated with retirement can represent a substantial challenge to anyone's capacity to adapt. These challenges are a type of life transition/developmental task experience that can be a focal point for counseling. There are many possibilities for counselors in helping people prepare for retirement, in providing support and other assistance during the experience of retirement, and in helping people live with the consequences of their past decisions and life's eventualities.

Changes in labor and retirement laws and reinterpretations of the Constitution may certainly affect the demography of employment and retirement. Such changes most likely will increase individual freedom to choose. Opportunities for choice, as we well know, are associated with the needs for information, decision making, and planning. The implication is that the need for counseling will be greater as legal changes occur and as the demographic configuration of employment/retirement is increasingly the result of individual choice.

As with the other characteristics, the income and financial status of the older population vary substantially. A small number of older people is well-to-do, but the greater part finds itself with lower income and assets than younger persons. In 1975, the median income of an older family was $8057, which equaled slightly more than half the income of younger families. For individuals who were living alone, the discrepancy was approximately the same; older individuals had median incomes of $3311, while younger individuals had $6460. Although imcomes have risen for most persons over the past 10-15 years, the relative financial position of older compared to younger people has improved only modestly. During the period from 1960 to 1975, the older family's median income increased from 49.1 percent to 54.8 percent of the younger family's income (see Graph 5). Thus, minimal progress has been made in the comparative positions. The situation with unmarried older individuals is similar. In 1960, older individuals had 41.0 percent of younger individuals' income, while by 1975, older individuals' income had increased to 51.3 percent (Brotman 1977a).

In 1975, the poverty threshold for a two-person older family was set at $3232; 15.3 percent had incomes under this level, compared with 12.3 percent of the total population below the poverty level. Older people comprised 10 percent of the United States population but 13 percent of the poor (Brotman 1977a). Most of these older people became poor after they reached age 65. Many were widows who found that their pension benefits ended when their husbands died or that their savings were simply not sufficient to withstand the ravages of inflation.

Poverty in the older population has been reduced somewhat since the implementation of the Supplementary Security Income (SSI) program and the expansion of Social Security retirement benefits. Still, so long as many persons are struggling to meet the minimal survival needs, they cannot be expected to spend their meager funds for preventive health care or even to seek help for conditions or maladies that are not covered by Medicare or Medicaid.

Financial considerations are an obstacle to private counseling services for most older people. Even more than younger adults, older persons are dependent on public counseling services. Although older people commonly seek medical assistance because of a need to talk with a professional person rather than because of a physical problem, their needs are not adequately recognized or provided for in our service system. Counselors and counseling organizations need to make the public and government aware of the non-physical needs of older people and the negative effect of their limited finances on their self-esteem and ability to obtain services — including counseling services.

At the same time, most older people have the financial resources to live self-sufficiently; overgeneralizing about the poverty of the aged is unrealistic. Some older people are offended by those who suggest by their actions that the old must be poor.

THE DEPENDENCY RATIO AND THE OLDER POPULATION

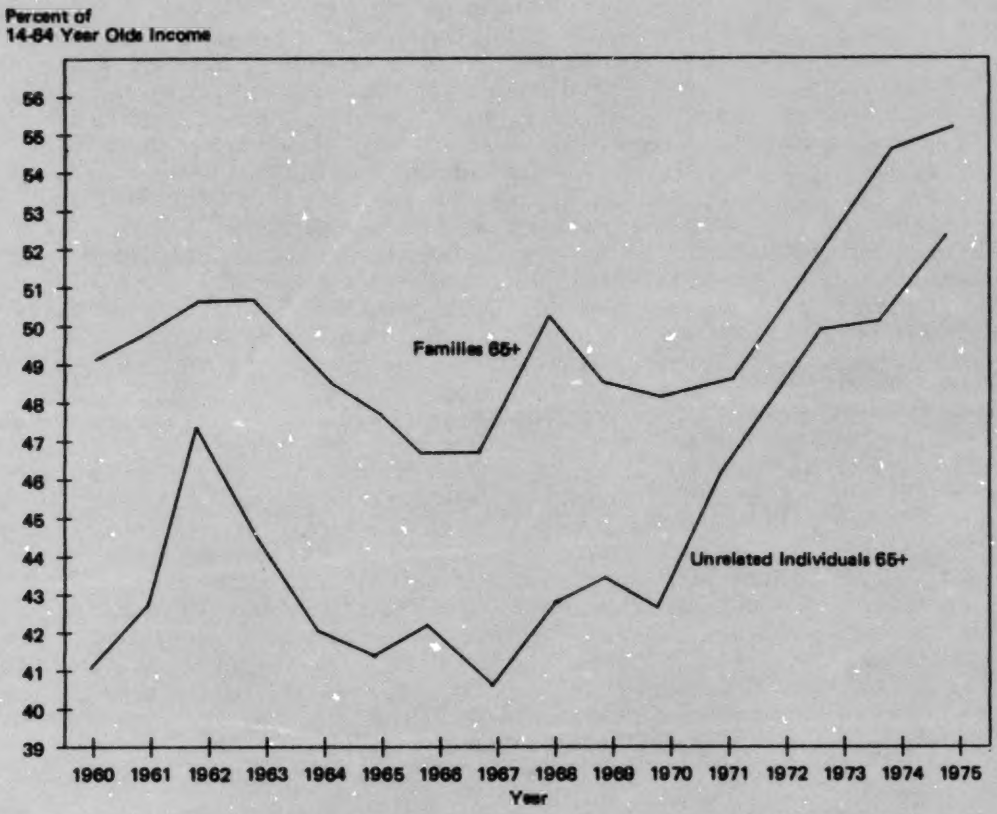
The dependency ratio is a comparison of the number of people outside the potential work force with those who are in the potential work force. Dependents include both those under 18 years of age and those 65 and over. The young currently have a dependency ratio of .53 (53 young people for every 100 persons aged 18-64). This number has remained constant for the last 50 years but is expected to fall to .44 by the year 2000 if the birthrate remains low (Brotman 1977b).

The dependency ratio of older people has increased during this century. As Graph 6 shows, the ratio has grown from less than ten older people to 100 workers (.10), to the present ratio of approximately .18 (Cutler & Harootyan 1975). This growth is expected to continue until the year 2020 when the post-World War II birth group reaches age 65 (Brotman 1977b). In the future, then, the dependency ratio of the older population will increase modestly. The number of older people in the U.S. population is not expected to grow so large as to place an undue economic or social strain on the working population. Furthermore, the youth dependency ratio is expected to decline so that young people will place a reduced strain on the resources of the nation. Also, about a fourth of those between 18 and 65 are not in the labor force.

The dependency ratio is an artificial figure and is not a measure of the number of people within or outside the work force. It is an arbitrary measure of potential workers and non-workers. If earlier retirement continues to be popular, many more people in the 55 to 64 category may leave the

GRAPH 5

Older Persons' Income As a Percent of Younger Persons' Income

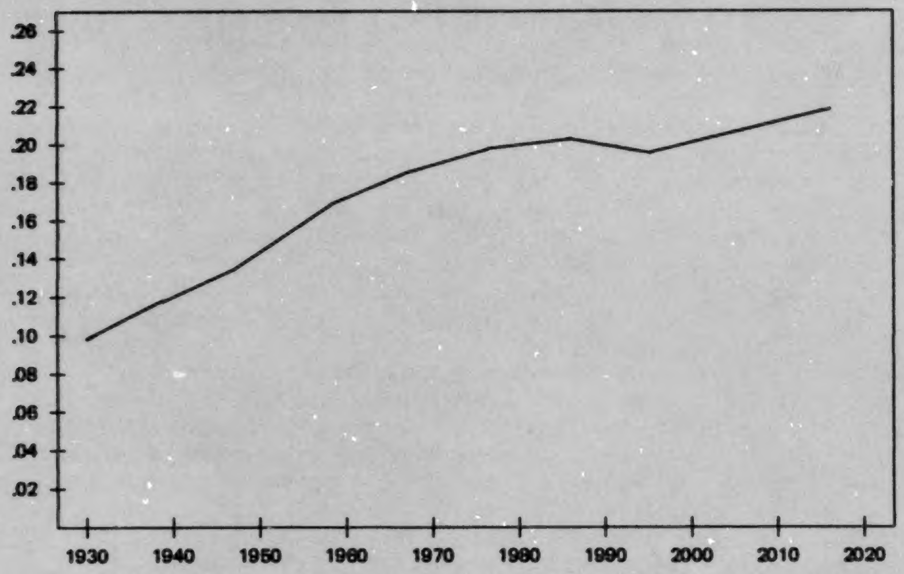


Year	Families 65+	Unrelated Individuals 65+	Year	Families 65+	Unrelated Individuals 65+
1960	49.1	41.0	1968	49.9	42.6
1961	49.8	42.7	1969	47.6	43.0
1962	50.6	47.2	1970	47.9	42.3
1963	50.5	44.3	1971	48.7	46.0
1964	48.4	41.9	1972	50.3	47.8
1965	47.4	41.2	1973	49.7	49.1
1966	46.0	41.9	1974	54.3	49.1
1967	46.2	40.5	1975	54.8	51.3

Source: Brotman, Herman B., *Income and Poverty in the Older Population in 1975.*

GRAPH 6

Dependency Ratio of 65+ Population



1930	.097	1980	.182
1940	.118	1990	.195
1950	.133	2000	.215
1960	.167	2020	.213
1970	.177		

Sources: Cutler, Neal E. and Harootyan, R. A., *Demography of the Aged.*
Brotman, Herman B., *Population Projections.*

work force and become dependent upon the productivity of younger persons. On the other hand, if attempts to outlaw mandatory retirement are successful, more older people may remain in the work force. This possibility would reduce the economic strain caused by persons who are retired but receive some share of the gross national product.

PHYSICAL HEALTH

Aging and illness are separate entities. Yet some persons believe that an individual growing older becomes ill. This belief is not true, although older people do require more medical care than younger persons. Acute conditions, which can be cured, are common in the younger population. Older people are more likely to have chronic, degenerative conditions that require long-term regimens, special facilities, and great patience of the provider and recipient of services. Approximately 86 percent of the non-institutionalized elderly have at least one chronic condition. The condition may be major or as minor as correcting sight with eyeglasses (Brotman 1976).

Older people have twice as many hospital stays as younger persons, and they stay twice as long. They visit physicians 50 percent more than younger persons. Taken in total this means that the per capita annual health expenditure by older people ($1218) is nearly three times as large as that of younger persons (Brotman 1976). In 1973-74, the older population had a total health care bill of $26.7 billion, 29.5 percent of the $90.3 billion spent on all health care. Before Medicare and Medicaid, each older person accrued an annual health bill of $441, of which 30 percent was paid by public sources. Today, Medicare and Medicaid pay 60 percent of the total health costs of older people. But even with the assistance of these two major public programs, older people were paying nearly 65 percent more out of their resources for health care ($487) in 1974 than they did eight years earlier ($308) (Brotman 1976).

About 19 percent of the older population is limited in mobility by illness. Five percent is housebound, 6 percent needs some assistance from another person to move about, and 8 percent needs some mechanical aid (Brotman 1976). Any comprehensive counseling service would need to have a substantial home visitation component since health factors alone would make it difficult or impossible for one-fifth of the older people in the community to get to counseling.

The demographics of health status verify that problems of physical health are a significant factor in the lives of older people. It follows that counselors working with older people need to be familiar with the physical aspects of aging and with certain basic information about the more common degenerative conditions. Module III on physiological and sensory changes in the aging process addresses this need. The demographic data also suggest the need for counselors to be very familiar with the health care system, including insurance programs and referral sources.

The fact that most older people are able to get "out and around" reinforces the reailty that generic community services need to be prepared to serve older persons as part of their clientele.

Health care costs have risen substantially in the past few years, and the burden of this increase has fallen heavily on older persons. The future will likely maintain this trend. High cost is one of the factors that may make it more difficult to get government funds to support non-physical health needs, and difficult for older persons to afford "non-essential" and problem-preventive services at their own expense in the private sector.

MENTAL HEALTH

Meaningful indicators of the mental health status of the older population are easy to find. Specific, valid statistics are less so. With any age group, a most fundamental question remains, what is mental health? This question is even more pertinent to older people. If health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" as defined by the World Health Organization (Butler & Lewis 1977), then who among us is healthy? If mental health is the fullest possible realization of our mental and emotional potentialities, and not just the absence of neuroses or psychoses, then who among us is not sick? Statistics are hardly necessary for us to know that old age is a period in which stressful situations occur with increased frequency and in which we are called on increasingly to adopt and adapt. As Butler has expressed it, "Old age is the period in life with the greatest number of profound crises, often occurring in multiples and with high frequency. The critical psychological events in this age group are the familiar human emotional reactions to death and grief, diseases and disabilities. Depression and anxiety escalate, defensive behavior is seen, earlier personality components may reappear in exaggerated forms, and newly formed functional states are frequently noted. These conditions require psychotherapeutic efforts, indepth as well as supportive" (Butler & Lewis 1977, p.1). As one of several emotional problems and reactions, Butler and Lewis (1977) discuss grief and quote a very touching passage by St. Augustine in his Confessions:

> "I pressed her eyes closed, and a huge wave of sorrow flooded my heart and flowed outward in tears.... What, then, was it which caused grevious pain within me, if not the fresh wound arising from the sudden breaking of a very sweet and cherished habit of living together? Since I was there bereft of such great comfort from her, my soul was wounded and it was as if life which had been made one from hers and mine was torn to shreds .... It was a relief to weep in Thy sight about her and for her, about myself and for myself."

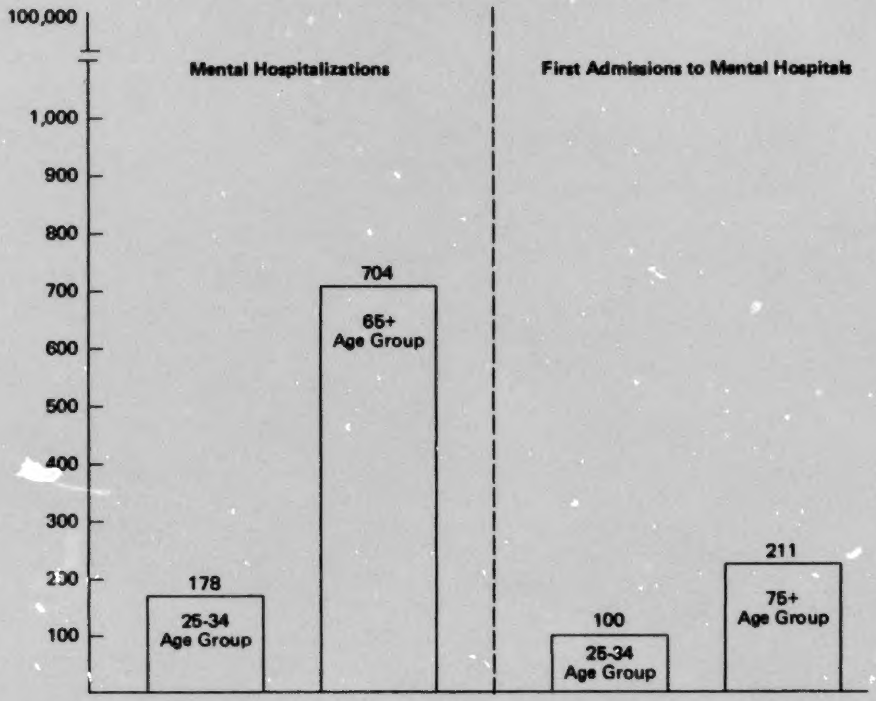
The emotional experiences of aging do not lend themselves well to statistical treatment. Not only problems of definition, but problems of diagnosis become exaggerated. In discussing clinical diagnosis for the functional psychoses, Langley emphasizes the importance of accurate information, but states that, "To make adequate personal contact with an elderly, easily fatigued, perhaps forgetful, apathetic, deaf and partially sighted patient and to elicit the depth of information required for a psychiatric diagnosis and appraisal can be a stern test of clinical technique and dispassionate patience " (1975, p. 327). Certainly the difficulties of diagnosing psychoses in older persons could be an extremely difficult task and would clearly affect the validity of demographic data regarding the incidence of psychoses. Also, Dr. Langley's description of older people may suggest a certain expectation, on the part of at least some psychiatrists, regarding the characteristics of older people that mitigates against objective evaluation. Interestingly, he states that "for the unwary or hasty, diagnostic error is most likely to be in the direction of underestimating the capacity and/or distress of the patient, to his ultimate detriment" (p. 327).

Butler and Lewis (1977) identified another problem in diagnosing mental illness, which makes diagnosis of older persons increasingly difficult, and that is the "doctrine of single diagnosis." In older persons particularly, multiple and interrelated problems commonly exist. He has offered as an example a diagnosis of senile, arterosclerotic or other chronic brain disease that omits an additional, also correct, diagnosis of superimposed, reversible brain syndrome. Another example is the tendency not to recognize the emotional component of physical illnesses. He encourages those making diagnoses to search for possible combinations of problems where some may be less apparent than others. The implication again is that statistical data on the mental health of older persons is subject to particular inaccuracies.

One frequently used indicator of the mental health status of various groups is the admission rates of the groups to mental hospitals. Wolff (1970) has indicated that about 30 percent of all new admissions to state psychiatric institutions in 1970 were 60 years of age. Pitt (1974), an English psychiatrist, has estimated that the likelihood of admission to a psychiatric ward in England increases sharply with age and that the first-admission rate to mental hospitals for those over 75 is more than twice that of those in middle age. Riley and Foner (1968) report the admission rate of patients in American state mental hospitals rises from 178 per 100,000 for the 25 to 34 age group to 704 per 100,000 among those 65 years of age and older. Those over the age of 75 also have a higher rate of first admissions than those between 25 and 34, as indicated on Graph 7.

GRAPH 7

Hospitalization Rates in State Mental Hospitals*



*Thorson, J. A. 1978 (in press).

Despite their frequent use, admission rates to mental hospitals are a dubious indicator of the mental health status of any group. In 1953 mental hospitalization rates were found to vary from 1.5 patients per 1,000 population (Tennessee) to 6.36 patients per 1,000 (New York) (Kleemeir 1960). This suggests that hospitalization rates are the product of other factors in addition to mental illness. Facilities, programs, and policies all affect admission rates. How such variables could affect general admission rates is easy to see and predict, but their exact nature and impact on older persons is difficult to determine. Some people are probably more inclined to put older persons into a mental hospital. Others may be more inclined to keep them at home. Many persons in nursing homes are not mentally healthy. Although the admission and new admission rates and the proportion of those in mental hospitals who are old are all very high, it is difficult to have confidence in those figures as a precise gauge of mental health among the older population.

Suicide rates may also be indicative of mental health, although suicide rates are also imperfect gauges at best. In England, where the over 65 age group represents 12 percent of the total population, about one-third of those who kill themselves are 65 years of age or older (Pitt 1974). In the United States the figure is probably 25-30 percent (Resnik & Cantor 1970). Suicide rates are presented in Table 2. Suicide is one of the 10 leading causes of death in the United States and is particularly

TABLE 2

Suicides per 100,000 Population by Age and Sex in 1974*

Age	Male	Female
5 to 14	1.4	0.4
15 to 19	11.0	3.2
20 to 24	24.1	6.2
25 to 29	23.8	8.1
30 to 34	22.6	8.7
35 to 39	23.1	9.8
40 to 44	22.5	12.4
45 to 49	25.8	13.2
50 to 54	27.3	12.8
55 to 59	30.7	11.2
60 to 64	29.7	8.3
65 to 69	30.5	8.3
70 to 74	36.4	7.6
75 to 79	42.5	7.7
80 to 84	45.2	5.7
85 and over	45.2	3.8
All ages	18.1	6.5

*Based on U.S. Public Health Service data.

From: Butler, Robert, and Lewis, Myrna, *Aging and Mental Health* 2nd Ed. C.V. Mosby Co., St. Louis, 1977. Jr 68.

common among older white males. Suicide rates for women and for Black men peak in the middle years and are lower in later years than those of white males (Butler & Lewis 1977).

Even though the general inattention to the mental health of older people, the specific diagnostic and methodological problems, and even the meaning of mental health may complicate the effort to picture the status of the older population, the evidence does seem to indicate that the mental health of our older population is worse than that of those who are not old. Considering the multiple challenges to adaptation prevalent in older age groups, it would be surprising if mental health problems were not more frequent among older age groups. Just how much worse we cannot say.

Older people who have poor mental health may, in fact, be less visible than their younger counterparts. When a man of thirty stops having sexual relations with his wife, stops going to work, and doesn't leave his house for six straight weeks, it will surely be recognized that something is wrong. But if a man of 70 does the same thing, it may well be unnoticed. Or if it is noticed it may be passed off as something inevitable and natural for that age. In the final analysis, we really don't know how many people may be suffering in silence (Pitt 1974) and even believing it is natural to do so.

The mental health needs of older people are far beyond the combined capacities of all the helping occupations to meet fully. This is true not only in terms of numbers involved but also in terms of the complexity of the problems and the multiplicity of factors contributing to them.

So far as implications for counselors are concerned, the data suggest a need so monumental that it ceases to be a critical factor in planning. The more relevant issue is the will and financial and structural means for seriously addressing the problem.

MINORITY AMERICANS

The demographic descriptions of older persons presented to this point relate to the total U.S. population; thus, many racial subgroups have been combined with the larger white population, obscuring their unique characteristics. In this section demographic information is presented for some of these subgroups — Blacks, Asian Americans, Native Americans, and Hispanic Americans.

The way of life of any group, particularly a racial minority, is, of necessity, influenced by the problems inherent in its minority status. Patterns of caring for children and elderly, ways of earning a living, health measures, and even survival of the group itself are influenced by its position within the larger society. For minority Americans, survival has not been easy. Prejudice, discrimination, and mistreatment have been predominant throughout most of this country's history.

In response to the special difficulties of minority Americans, these groups have developed coping behaviors which have given rise to distinctive subcultures. Although there is a bond of unity among the groups based upon their minority position in society, the diversity among them is equally important. No two minority groups share the same cultural or historical background; each is best viewed singly rather than in combination with the others. Consequently, data for each of the four are discussed separately.

Older Black Americans

The number of Black aged has steadily increased during this century and has grown rapidly in the past 20 years. In 1960 there were 1.2 million older Blacks. This number increased to 1.8 million by 1977. By 1980 the older Black population is expected to exceed 2 million, a growth of approximately one-half million since 1970 (Butler 1975).

Elderly Blacks are geographically distributed in a pattern similar to that of the total Black population (Brotman & Williams 1971). The largest concentrations are found in the southern states (61 percent), while the five largest states (California, New York, Pennsylvania, Texas, and Illinois) include 29 percent.

Most Blacks now live in central city areas (56 percent) compared to only one fourth of whites. Older Blacks follow the same pattern, typically living in the least desirable portions of the metropolitan areas, the inner cities.

The marital status of the Black elderly closely parallels that of their white counterparts. In 1970, 52 percent of older Black males were married, compared with only 24 percent of the females (Bureau of Census 1973a). Since Black women tend to outlive Black men, there is a higher number of older Black women who are widowed and alone than there are widowed white females living alone.

The life expectancy of a Black man was 61.1 years in 1971, six years less than that of white males. For both men and women in the 45 to 64 category, the mortality rate is nearly twice as great for Blacks as for whites. As a result, Black women are much more likely to experience early separation from their mates and to find themselves living alone or in families with female heads (Bureau of Census 1973a).

In 1974, only 47 percent of the Black aged lived in husband-wife families compared to 59 percent of white older persons. Forty-one percent of the Blacks lived in female-headed families compared to 31 percent of the white aged. Thus the higher rates of Black mortality and family breakup are problems that continue to affect the lives of Blacks during the retirement years.

In 1970, 22 percent of older Black males were in the work force and 12 percent of older Black females were employed. These figures closely paralleled the older white labor force participation, yet the median income for older whites was almost double that of their Black counterparts. Voluntary retirement at old age is much more a matter of choice for white women than for Blacks. To understand the economic and income situation of older Blacks, it is necessary to keep in mind their previous experience in the labor force (Bureau of Census 1973a). During the critical preretirement years when most workers are accumulating savings, Social Security quarters, and other pension benefits, Blacks experience lower incomes and unemployment rates twice that of whites.

The implication of this employment history is that older Blacks tend to be poor. In 1973, 37 percent of all older Blacks had incomes below the poverty line, a figure 3 1/2 times higher than the percentage of older whites living in poverty (Bureau of Census 1973a). This means that with a lifetime of low income status and an even more difficult time in the later years, older Black persons are likely to suffer more health problems and to live in environments which are less conducive to good health than are white Americans. These facts are reflected in higher mortality rates for older Blacks. To an even greater extent than with older whites, counselor contact is likely to be through public rather than private agencies. The problems faced by the older population in general are magnified for older Blacks, both in frequency and degree.

Older Native Americans

Statistics about Native Americans are frequently inadequate, inaccurate, or unavailable. A survey of the Library of Congress catalog files reveals approximately 417 cards on Indian legends and pottery, but none on income or population. In fact, there is still some confusion in determining who should be classified as an Indian. In the data reported here, the Bureau of Census counted as Native Americans those persons claiming Indian descent or who specified the name of an Indian tribe. By whatever standards one would choose, however, Native Americans, and particularly the aged within that group, constitute one of the most deprived segments in our population (Administration on Aging 1977).

The 1970 Census revealed that 763,594 American Indians live in the United States. Of this number, 43,802, or 5 percent, were 65+ years. These older Indians ranked as the third most populous elderly racial minority in the United States, after elderly Blacks and older Hispanic persons.

Indians over the age of 55 are distributed geographically in the same pattern as the total Indian population. They live in all sections of the country, but are concentrated in states which have reservations. Five of these states (Oklahoma, California, Arizona, New Mexico, and North Carolina) account for 53 percent of these older persons. Nearly 28 percent of all Native Americans live on the 115 reservations throughout the United States. Thus a very high proportion (57 percent) of Native Americans lives in rural areas (Administration on Aging 1977).

In 1970, there were 20,702 Native American males over the age of 65, 57 percent of whom were married. For females over 65, only 32 percent were still married (Bureau of Census 1976a). The fact that the average life expectancy for Native American males was only 46 years (substantially below that of other minotiry groups) helps to explain why such a small percentage of women is married. Poor health and sanitation on many of the reservations undoubtedly contribute to the mortality figures and indicate the need for care and concern for this minority group.

Of the 43,802 older Native Americans, only 11 percent were in the labor force in 1970. Laborers, service workers, and craftsmen accounted for 53 percent of the employed males; for females, the largest categories were service workers (22 percent), private household workers (20 percent), clerical workers (14 percent), and craftsmen (13 percent). Because of the manual nature of the employment, the median income for Native Americans was only $1,654 for males and $1,162 for females in comparison to the national average of $4,962 in 1970. With incomes this low, most older Native Americans are not able to purchase the amount and quality of services they need and are likely to suffer from numerous preventable conditions which shorten lifespan and reduce the quality of life (Administration on Aging 1977).

The relatively small number of Native Americans combined with their shorter life expectancy means there are only small numbers of older Native Americans to be served. But like other minorities, they are often concentrated geographically and require extensive service on a local level. Their extreme economic and health problems and their short life expectancy suggest the possible need to alter guidelines by which some service programs operate. Present minimum age requirements for participation in the Senior Companion Program, for example, mean that few Native Americans can ever benefit from the program because they will have aged and died before being old enough to qualify.

Hispanic Americans

Hispanic Americans include individuals whose background is Mexican, Puerto Rican, Cuban, Central or South American or other Spanish origin. Our primary focus will be on the three largest subgroups within this population — Mexican Americans, Puerto Ricans, and Cubans.

In March of 1975, about one of every twenty persons in the United States (11.2 million) was of Hispanic origin. The Hispanic population has a substantially larger number of younger persons than the general population. Only about four percent of Hispanic Americans is 65 or over (Bureau of Census 1976b). Of the national groups, Mexican Americans over 65 numbered 221,000; Puerto Ricans, 25,500; Cubans, 63,600; and others, 92,000.

The majority of Hispanic Americans (6.4 million) lives in the five southwestern states of Arizona, California, Colorado, New Mexico, and Texas. The elderly follow a similar pattern of concentration, with 41 percent in these five states and an additional 20 percent in New York and Florida (Bureau of Census 1973b).

Most of the 2.5 million Hispanic families (83 percent) live in metropolitan areas. Like the general aged population, most of the elderly (84 percent) are also urban dwellers. Cuban elderly were the most urban of the subgroups, with 98 percent living in metropolitan areas, compared to 97 percent of Puerto Ricans and 86 percent of Mexican Americans (Bureau of Census 1976b). As with most other groups, older Hispanic males are likely to be married (63 percent) while older females are not (30 percent).

In 1970, approximately 23 percent of the older males and seven percent of the older Hispanic females were in the work force. For male workers, 70 percent were in the occupational category of service workers. For females the situation was similar, with 14 percent being household workers; 19 percent service workers; and 24 percent listed as operatives. Few men or women occupied professional, high-level administrative or managerial positions. Lower-level employment has been responsible for the limited income of Hispanic Americans. In 1974, older Hispanic men had a median income of only $3,185, while older Hispanic women had an income of $1,833. Of the latter group, 74 percent had less than $3,000 annually in income from any source. Limited income carries obvious implications for the nutrition, health care, living arrangements, and economic welfare of these individuals.

Older Asian Americans

The Asian American population of the U.S. is composed primarily of Japanese, Chinese, and Filipinos. During much of this century, immigration quotas on persons from outside Europe or the Western Hemisphere greatly restricted the entry of Asians into this country. Since the end of World War II, revisions of immigration laws have allowed a gradually increasing number of Asians to enter, and their population has grown markedly.

The Japanese are the largest Asian-American subgroup, with a 1970 population of 588,324. Approximately 8 percent were over the age of 65. The Chinese are the second largest Asian-American subgroup, with a 1970 population of 431,583. During the 1950s, the Chinese population increased by 84 percent, with two-thirds of the addition being new immigrants. Few elderly have immigrated; so only 6 percent of Chinese are older (Bureau of Census 1973c).

Filipinos are the third largest of the Asian-American subgroups (336,731). They are now migrating to the U.S. in larger numbers than any other Asian group. Since 1970, an additional 90,000 Filipinos have immigrated, representing an increase of over 25 percent in seven years. Elderly Filipinos constitute about 6 percent of the total Filipino-American population (Bureau of Census 1973c).

Older Asian Americans are distributed similarly to the total Asian-American population. Thirty-seven percent of the older Japanese reside in Hawaii and 31 percent in California. California, Hawaii, and New York have 76 percent of the 65+ population of older Chinese. Approximately 75 percent of older Filipinos immigrated earlier in the century and now live in California or Hawaii (Office of Special Concerns 1974).

Asian Americans are one of the most urban of any ethnic population in the United States. In 1970, 97 percent of older Chinese Americans, 84 percent of older Japanese Americans, and 77 percent of older Filipinos lived in urban areas, as compared to the national average for older people of 73 percent. Much of this urban concentration can be attributed to the arrival of large numbers of new, urban-oriented immigrants and to a move by younger U.S.-born Asians to the cities.

One out of every five elderly persons in the three Asian-American subgroups is single. As in the total population, many older Japanese women who have outlived their husbands are on their own. But Chinese and Filipino elderly males outnumber females by as much as four to one (Bureau of Census 1973c). Due to immigration laws mentioned previously, the Chinese population since the beginning of the century has been predominantly male. Although the differential between males and females overall has been decreased over the past decade, among the elderly, males still comprise 57 percent of the population.

The types of jobs held by Asian Americans are consonant with their educational attributes. In 1970, 18 percent of all elderly Japanese and Chinese were in the labor force, as were 25 percent of the Filipinos. Employment as laborers, operatives, and service workers ranked highest among the elderly in all three subgroups (Bureau of Census 1973b).

In 1970, the median income for elderly male Asian Americans varied from a high of $2,528 for Filipino males to a low of $1,943 for Chinese males. Among the older female population, the trend was altered somewhat, with Japanese women ranking the highest ($1,312) and Filipino women the lowest ($1,130).

Implications of Demographic Data: Older Minority Americans

About 2,345,000 older Americans are members of minority groups. They are a minority within a minority. The problems associated with aging and being an older person are compounded by the problems of being a minority member. Although they represent a substantial portion of the older population, they tend to be less visible than their majority member counterparts because they tend to live on reservations, in ghettos, or in other ethnic communities which isolate them from the rest of the population. Because they tend to cluster together, their impact and service needs can be much more substantial on the local level than they might appear to be on the national level. Although older members of minority groups may get more support from an extended family, the additional support cannot compensate for their depressed income and economic status.

The need for special understanding and skills for counselors who work with minority member clients and the need for counselors who are members of minorities are magnified when considering counseling services for older minority persons. Data on mortality rates, health, employment, unemployment, and income support a strong advocacy role for those wishing to assist older Americans who are members of minorities. Older Americans who are also members of a racial or ethnic minority are in double jeopardy. Demographic data for these groups show important differences between them and the older population in general, as well as differences among the minority groups themselves. This implies a need for flexibility in establishing or interpreting program guidelines and a need for service providers at the local level to have specific knowledge of their local population rather than overgeneralizing from national data.

SUMMARY

As we have noted throughout this section, the older population of the United States has shown consistent and sustained growth during this century. In both absolute numbers and percent of the total population, the 65+ segment has increased faster than other age group. This has resulted from a modest increase in the life expectancy at age 65 and from a decline in the fertility rate since 1950. This expansion of the older population is likely to slow for the next 25 or 30 years, but then expand quickly as the post-World War II group reaches old age.

It is anticipated that older people in the future will be healthier, better educated, and financially better off than were those of the past. This should mean that many difficulties will be reduced, and that they will have greater resources with which to deal with the difficulties that arise.

On the other hand, demographic trends show a clear increase in the median age of the older population. There will be more persons over the ages of 75 and 85 in the future than has been the case in the past, and these persons especially will need health care and supportive services. We can also expect a continued decline in the sex ratio. Many women will be widowed and will require the assistance of family members, community agencies, or government programs.

These two developments are likely to increase pressure for institutional placements in both health and mental health areas. Government programs currently stress the advisability of community alternatives, but these remain generally unavailable, and increased resources will be necessary to expand them.

Pressure also results from the insufficient availability of families to assist older persons. The past ten years have seen a significant movement toward the Federal government becoming the provider of services. Federal involvement has required great amounts of resources and is currently costing over $100 billion annually. The expectation of federal support is likely to continue to grow in the future, and extensive debates in Congress will likely question the justification for these expenditures on older persons.

Demographic data for the total elderly U.S. population are not always an accurate guide for understanding the situation of various groups within the total. This is certainly true and an imperative fact to remember when considering the status of elderly minority racial groups. These groups not only differ from the majority elderly white population but from the other minority racial groups as well. One significant factor, however, that the older minority groups share is the magnification of some aspects of aging. Higher mortality rates and lower income are even more characteristic of the older racial minority groups than of the total older population.

Looking forward, demographers have taken a conservative position, describing what is known at present, and then extending it into the future. This is a safe approach, but it eliminates the possibility of new or unforeseen events (Peterson et al. 1976). It does not consider the possibility of new inventions, major changes in government philosophy, medical breakthroughs, or social patterns. The projections are as good as can be made, but they should not be considered infallible for they may prove inaccurate.

Implications for Counselors

The demographics of aging need to be studied because they are necessary to an understanding of our general national population trends. They are part of the data that can help us understand and predict changing market demands, service needs, tax pressures, labor force changes, and nearly every aspect of our economic and social structure. Increasingly, the demographics of aging also have political importance. In conjunction with our cultural beliefs and values, demographic data provide the base for social planning. The demographics of aging also need to be understood because they reveal information of specific relevance to service delivery programs and of use to individual service deliverers — including counselors. Knowledge of demographic facts can dispel some of the wrong ideas about aging and help us dispel mistaken and potentially harmful beliefs held by others. Older people themselves are sometimes victimized by their own mistaken assumptions about aging and older people. Some of these mistaken assumptions can be corrected if those working with the older person are not sharing the same wrong ideas but instead are aware and can share relevant, accurate information.

The fact that the older population has been increasing and will continue to increase steadily in both absolute numbers and relative proportion of our total population is probably the most important single demographic fact. It is from that fact that much of the general social, economic, and political implications flow. It is that fact that has helped to increase awareness of the older population. They are both seen and heard more than ever before. The increased numbers of older people, in combination with a general increase in social consciousness regarding "special" groups and an awareness of declining school enrollments, make the potential service opportunities for counselors with older people seem logical and important.

When facts about the life conditions of older people are added to the facts about numbers of people involved, the apparent needs for counseling and service opportunities for counselors seem more obvious. The developmental and crises situations faced by older persons — such as loss of employment, decreased income, loss of spouse, loss of age mates (acquaintances, friends, relatives), declining health, and increased health care costs — suggest a potential for counseling as well as for other services. It is very important that counselors recognize that other groups are also necessary and important in the delivery of service to older persons. In many ways older persons have much to offer. Health care workers of many types are needed, and their training programs are being oriented more toward servicing the elderly. Other groups such as social workers and recreation specialists also see themselves, and are seen by program administrators, as having important contributions to make.

The implications of this are that counseling is not the only professional group to recognize the needs and potential of the older population. The numbers of people, the rate of their increase, and nature of their situation are too much to be ignored. Older people are attracting a lot of attention and if professional counseling is to be part of the service system for older people, counselor organizations, counselor education programs, and individual counselors should react quickly and qualitatively. Counselors should also expect to work with a variety of others, some of whom may see counselors as competitors and as duplicators of the services they offer. Leisure counseling, for example, is seen by some as outside the service of professional counseling. The demographic facts of aging and the increasing awareness of those facts are attracting the attention of many groups with whom counselors may find themselves competing, but hopefully cooperating. Unfortunately for those to be served, even the best efforts of all groups working in the most cooperative and coordinated way imaginable will meet only partially the needs of those to be served. We simply do not know enough and will not have sufficient resources to do everything, even in a combined effort. Hopes that others alone or in combination with counselors may get all the work done are unduly optimistic. Concern that counseling may be restricted from contributing significantly to improving the aging experience because of political and legislative activities may well be appropriate.

Listed below are some additional, relatively specific, implications of the demographic data:

1. Since the older old people (those over 75 years of age) are the fastest increasing part of the 65+ population, the demands for physical health services will be very great. These are the most expensive services, and the bulk of available funds for older people is most likely to go in that direction, rather than for retirement adjustment or other such programs oriented more toward the younger old. Since the physical needs are more obvious, counseling-type needs may require more action from counseling organizations if they are to be recognized and counselors' potential contributions better known.

2. When facts about the geographical distribution of older people are considered, we can see that all communities will have some older residents. (Even if there is an apartment building or block that has no older residents, there are almost certain to be many sons and daughters of older people. Some of these sons and daughters have concerns for their parents and often are involved in very serious problems related to them.) Demographic data or living patterns also suggest that some areas have proportionately more older people than other areas and have different demographic trends. This suggests a need for identification of local data for planning in relation to local situations; over-reliance on national data or trends may be quite inappropriate.

3. Since the life expectancy of men is less than that of women, the potential clientele, generally speaking, will be women. The concerns of older women need special emphasis in the training of counselors and the design of service delivery. The greater number of older women may make it relatively easy to obtain funding for women-oriented programs. On the other hand, there is a considerable number of older men, and counseling as well as other service groups should guard against the neglect of these persons who might otherwise become a forgotten minority within a minority.

4. Services for "lonely" persons, or those living alone, are especially likely to have female clientele. There are more older women than men, and more of the older men are married than older women. This is because men tend to marry younger women, and more older men remarry than do older women. Proportionately, there are more older single women than men.

5. Most counseling for older people will be through public rather than private fee services. This is even more true of the older population than it is for the rest of the adult population and results from the substantially worsened financial condition of older peoole in general.

6. Existing counseling services such as the employment service or vocational rehabilitation can expect their client populations to be increasingly older. This suggests the possible need for additional aging-specific training of counselors in these programs. Such training may be needed for increased self-awareness of beliefs and values, possible special counseling techniques, referral sources, and possibly other factors particular to working with older people.

7. Counseling programs aimed at serving the general population of older persons can expect most potential clients to be physically able to travel to the service. But no program for older people can be truly inclusive unless it also has a capacity for having home delivery of service and a capacity for providing transportation assistance for those who require it. Five percent of the non-institutionalized older population is homebound and another fourteen percent needs some human or mechanical aid in getting about.

8. The age to which older persons, on the average, can expect to live is greater than that for

persons just born or that of the population in general. Data on life expectancy at birth are not appropriate for use with older persons. Counselors can better assist middle-aged or older clients in life planning by using the most relevant demographic data available. Counselors can help allay the mistaken beliefs about life expectancy that some older clients or their families may have.

9. Demographic data differ substantially between sexes and among racial groups. This implies that at least in some instances sex- and race-specific data are more helpful for clear understanding than general data. General demographic data are not always accurate in reflecting the condition of specific subgroups within the population, and counselors sometimes need group-specific data.

10. In all respects except age itself, older people are as different from each other as from any other group. In fact, the differences between people may be accentuated with age and the indicators of central tendency less meaningful. In wealth and health, for example, the differences among the old are the most extreme of any age group. Only among the old are found both newlyweds and couples who have been married for 60 years. Counselors are accustomed to viewing people as individuals, but there is no group for which this is more essential than for the extremely diverse older population.

11. Mental health problems of older adults are of such magnitude that the best hope for substantial improvement is to change the general psychosocial milieu in which we age. This suggests that counselors should be social activists working against factors such as ageism that mitigate against mental health. It also suggests a training role for professional counselors fostering an improved quality of relationships between older persons and those with whom they are in contact; children, friends, neighbors, and providers of all kinds of services. The level of self-help within the community of older persons can be raised by using appropriately prepared counselors as trainers for large numbers of peer counselors.

Individual/Class Activities

1. Have students identify demographic and other effects resulting from such possible developments as the following:
   - Major breakthrough in the reduction of cardiovascular-caused deaths
   - Mandatory retirement age eliminated
   - Zero population growth for the next ten years
   - Doubling of interstate migration rates of older persons

2. Have students consider the implications for counseling of such changes as those listed above or others you or they may deem significant.

3. Have students determine state or local demographic facts related to older persons. In the process of doing this they could also learn about state and local offices on aging and a procedure they could use for identifying and using such local data.

4. Have students conduct surveys or polls to assess the knowledge of others (such as practicing counselors, other students, people on the street, their own families) about demographic facts. For example, they might ask about life expectancy, mortality rates, the proportion of the older population that is institutionalized, the relative income of the aged, the sex ratio of older persons, or employment or marriage rates.

5. Have students collect demographic data on their own family. Life span, income changes associated with aging, proportion of older relatives institutionalized, widowed, physically immobilized, etc. could be determined.

6. Conduct a survey or poll, such as described above, yourself and share results with students. Or, conduct your own family demographic study and share findings with students.

7. Divide class into groups of 3 or 4 people and ask each group to agree upon the two most significant demographic facts and the implications of those facts for counseling. Have groups share their conclusions with each other.

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OTHER SOURCES

Any library serving as a repository of U.S. Government documents (Most libraries would at least have an annual census report.)

U.S. Bureau of the Census.

Statistical Abstracts of the United States

U.S. Bureau of Labor Statistics, Special Labor Force Reports

U.S. Administration on Aging

State Commissions or Offices on Aging
Local Area Agencies on Aging
Most textbooks in social gerontology
Local or state health departments
City or county planning departments
Local health planning agencies
local council of government
University departments of planning or urban studies
Voter registration records
County vital statistics office
University urban research centers

Evaluation and Assessment

Demographic data lends itself most readily to objective assessment procedure. It is essentially a collection of facts, true or false, and multiple-choice items that easily can be constructed to determine knowledge of those facts.

Some of the individual/class activities suggested previously could also be used as a basis for evaluation. For example, the ability to extrapolate possible outcomes and implications of future events from available data could be assessed in the form of either reports or essay questions.

The ability of students to identify and compile local demographic data could be assessed by evaluating either written or oral reports submitted by students.

Objective Questions

1. Which of the following factors has most influenced the growth of the older population in this century?
   (a) a higher birth rate (b) control of the diseases of old age
   (c) control of the diseases of youth (d) a lower birth rate (e) migration

2. The fastest growing portion of the 65+ population is:
   (a) those under 75 (b) those over 75 (c) unmarried men (d) married women

3. The average income of the older family is approximately what percentage of the income of the average younger family?
   (a) 50% (b) 75% (c) 90% (d) 100%

4. About what percent of the older population are institutionalized?
   (a) 4% (b) 8% (c) 16% (d) 30% (e) 50%

5. The annual health bill of older people is about what percentage of the younger persons' bill?
   (a) 50% (b) 100% (c) 150% (d) 200% (e) 300%

6. The health care costs paid by older persons are:
   (a) about 10% of the actual cost (b) less than it was before Medicare and Medicaid
   (c) about 5% of the actual cost (d) more than it was before Medicare and Medicaid
   (e) not considered a major budget item

7. The proportion of the older population who are immobile or have health related mobility problems is:
   (a) 3% (b) 20% (c) 50% (d) 75% (e) not known

Essay Questions

1. Identify three demographic trends related to the aging of our population and discuss the implications of these trends for counseling
2. In what ways are our local demographic facts about older people alike and in what ways are they different from the national data on older people.
3. Discuss the implications of demographic information about older people for national, state, and local counselor organizations.
4. In what ways do you expect your personal experience of aging to differ from general demographic trends.

5. Which of the demographic trends are most susceptible to influence from these various sources:
   a. Federal government intervention, (a) programs (b) laws
   b. State or local government intervention
   c. Counselor intervention
   d. Medical developments
   e. Individual actions of older persons
   f. Personal planning or action by those not yet old.

   Describe what effect each of these influences could have on demographic trends.

MODULE II

ADULT DEVELOPMENT CHANGES AND COUNSELING CHALLENGES

Daniel Sinick

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ADULT DEVELOPMENT CHANGES AND COUNSELING CHALLENGES

Rationale and Objectives

Blocher (1966), Dinkmeyer (1970), and Zaccaria (1965), among others have argued the necessity of an understanding of the stages of human development and corresponding life tasks as a prerequisite for the effective implementation of guidance programs and the facilitation of growth through counseling. Chronbach (1954) has postulated that developmental tasks are related to certain basic psychological and social needs and ways of satisfying them. An understanding of the normative developmental tasks of a specific age group should lead to an appreciation of concerns and necessary adjustments that are likely to assume primary importance during that particular developmental stage of the life cycle. Moreover, the meaning of any one person's unique concerns can be more fully understood in the broader context of the experiences, changes, crises, and responsibilities characteristic of the age cohort of which s/he is a member.

Based on the assumption that "The psychological purpose of counseling is to facilitate development" (Tyler 1961, p. 17), this module will provide an overview of the developmental tasks associated with the last stage of the human life cycle and a discussion of the multiple kinds of crises that may challenge the psychological adjustment of the older adult. It is of utmost importance, however, to appreciate that although such developmental stages and tasks yield an overall perspective on and general understanding of later adulthood, there nevertheless exists a wide range of individual differences within this age group.

In short, it is important for counselors to understand the developmental stages, tasks, and changes of later life, a period of potentially stressful transitions with multiple losses and accompanying gains. Knowledge needed in counseling older persons relates particularly to career change, reentry into the labor market, preretirement preparation, retirement adjustments, self-destructive behavior and terminal illness, and survivorship or bereavement. The intent of this module is to provide a general overview of the developmental period of older adulthood in order to equip the reader with a theoretical frame of reference for understanding various issues that are discussed in greater depth in subsequent modules.

Specifically, the objectives of this module are as follows:

(1) To provide a broad and general overview of the significant and potentially stressful transitions common in later life that can be eased through timely and effective counseling.

(2) To impart the significance of developmental tasks and changes of later life and their relevance to counseling.

(3) To provide both a knowledge base for counselors and an affective foundation for empathic understanding.

(4) To suggest counseling expertise relevant to later developmental tasks and changes, transitions and stresses, losses and gains.

Content

DEVELOPMENTAL STAGES, TASKS, AND CHANGES

Development occurs throughout the life span, with accompanying changes and challenges. While recognizing continuity over the life span, various authorities, for descriptive and analytic convenience, have divided the life span into portions or segments. Regarded as running sequentially from conception or birth to death, these segments of life are commonly called stages, but are also called ages or passages. Within the process represented by such articulated phases, transitions are sometimes treated as critical periods or even events or crises.

Developmental Stages

Shakespeare's seven stages in As You Like It are paralleled by Feldman and Sears' (1964) seven stages: Infancy (0-5), Childhood (6-12), Adolescence (12-18), Young Adult (18-30), Prime of Life (30-42), Middle Age (42-60), Old Age (over 60). Buhler's (1933) five life stages were given vocational content in Super's (1957) five stages: Growth (Birth-14), Exploration (15-24), Establishment (25-44), Maintenance (45-64), Decline (65 and over). Hurlock (1975) presented ten finer stages: Prenatal (conception-birth), Infancy (birth-end of second week), Babyhood (end of second week-end of second year), Early Childhood (2-6), Late Childhood (6-10 or 12), Puberty or Preadolescence (10 or 12-13 or 14), Adolescence (13 or 14-18), Early Adulthood (18-40), Middle Age (40-60), Old Age or Senescence (60-death). Sheehy's (1976) "passages" are only six: Pulling up Roots (18-22), Trying Twenties (22-30), Catch-30 (30), Rooting and Extending (30-35), Deadline Decade (35-45), Renewal or Resignation (45-50).

Erikson's (1963) eight psychoanalytically oriented "ages" (Oral, first year; Anal, 2-3; Genital, 4-6; Latent, 7-12; Puberty-Adolescence, 13-19; Young Adult; Maturity; Aging) are respectively associated with resolution of Basic Trust vs. Mistrust, Autonomy vs. Shame and Doubt, Initiative vs. Guilt, Industry vs. Inferiority, Identity vs. Role Confusion, Intimacy vs. Isolation, Generativity vs. Stagnation, Ego Integrity vs. Despair. Havighurst's (1972) six stages (Infancy and Early Childhood, first six years; Middle Childhood, 6-12; Adolescence, 12-18; Early Adulthood, 18-30; Middle Age, 30-60; Later Maturity, over 60) suggest specific developmental tasks pertinent to each stage.

Developmental Stages

Erickson	Havighurst	Hurlock	Super
Birth–Year 1 ORAL (Basic Trust vs. Mistrust)		Conception–Birth PRENATAL	
Year 2–Year 3 ANAL (Autonomy vs. Shame and doubt)	Birth–Year 6 INFANCY and CHILDHOOD	Birth–Week 2 INFANCY	
		Week 2–Year 2 BABYHOOD	
Year 4–Year 6 GENITAL (Initiative vs. Guilt)	Year 6–Year 12 MIDDLE CHILDHOOD	Year 2–Year 6 EARLY CHILDHOOD	Birth–Year 14 GROWTH
Year 7–Year 12 LATENT (Industry vs. Inferiority)	Year 12–Year 18 ADOLESCENCE	Year 6–Year 10 or 12 LATE CHILDHOOD	
Year 13–Year 19 PUBERTY–ADOLESCENCE (Identity vs. Role Confusion)		Year 10 or 12–Year 13 PUBERTY or ADOLESCENCE	
		Year 13 or 14–Year 18 ADOLESCENCE	Year 15–Year 24 EXPLORATION
YOUNG ADULT (Intimacy vs. Isolation)	Year 18–Year 30 EARLY ADULTHOOD	Year 18–Year 40 EARLY ADULTHOOD	Year 24–Year 44 ESTABLISHMENT
MATURITY (Generativity vs. Stagnation)	Year 30–Year 60 MIDDLE AGE	Year 40–Year 60 MIDDLE AGE	Year 45–Year 64 MAINTENANCE
AGING (Ego Integrity vs. Despair)	Year 60 and up LATER MATURITY	Year 60–Death OLD AGE or SENESCENCE	Year 65 and up DECLINE

Developmental Tasks

According to Havighurst, A developmental task is a task which arises at or about a certain period in the life of the individual, successful achievement of which leads to his (or her) happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks. (1972, p. 2) Individual interactions with society or with other aspects of the environment are generally believed to influence the accomplishment of developmental tasks.

Normative expectations can be readily observed in Havighurst's tasks, delineated below, which start with those for middle age and later maturity.

Tasks of Middle Age (30-60)

Assisting teenage children to become responsible and happy adults.
Achieving adult social and civic responsibility.
Reaching and maintaining satisfactory performance in one's career.
Developing adult leisure-time activities.
Relating oneself to one's spouse as a person.
Accepting and adjusting to the physiological changes of middle age.
Adjusting to aging parents.

Tasks of Later Maturity (over 60)

(Note that in contrast to the tasks of the previous stage, these tasks all involve the concept of adjusting to loss or decline.)

Adjusting to decreasing physical strength and health.
Adjusting to retirement and reduced income.
Adjusting to death of spouse.
Establishing an explicit affiliation with one's age group.
Adopting and adapting social roles in a flexible way.
Establishing satisfactory living arrangements.

Havighurst (1972) acknowledged that his developmental tasks are "broadly defined units, each of which could be broken down into smaller tasks" (p. 8), nor did he regard his list as exhaustive. Among additional tasks applicable to middle age (beginning at 30): dealing with unfulfilled needs and potentials, dealing with a diminished sense of identity, balancing vocational/nonvocational achievements and rewards, adjusting to nonmarriage and divorce, adjusting to departure of children and death of contemporaries, adjusting to institutionalization, adjusting to the imminence of death. Although "adjusting" means coping rather than succumbing, one form of adjusting is accepting the inevitable.

Diversity and Variability

It would be an error, however, to accept any of the proposed stages or tasks as fixed and immutable, with no room for individual differences. Stages and tasks may arise at different times for different individuals and are dependent on many variables such as health, personality, values, attitudes, and social status. Biological, psychological, sociological, historical, and ecological variables are general factors influencing the individual applicability of the stages or tasks.

One's chronological age may very well be different from one's biological, psychological, social, functional, and subjective age. People who look old to others frequently do not see themselves as old. "Older people are in fact young people inhabiting old bodies," said Comfort (1976, p. 21), a view supported by Puner (1974): "Most people over 70 are secretly young, disguised in old skin" (p. 7). Despite "social clocks" (Neugarten 1968) representing social expectations and presumably regulating individual behavior, people deviate from expectations and display diversity, variability, heterogeneity — characteristics that Kalish (1975) sees as increasing with age.

Increased diversity with age results not only from individual differences but also from differences between men and women and between mainstream groups and minority groups. Some stages and tasks may be encountered either earlier or later by women and minorities; both of these groups, for example, often achieve satisfactory career goals later and women tend to be widowed earlier than men.

"When the empty nest, grandparenthood, retirement, major illness, or widowhood occur off-time," as Neugarten (1976, p. 196) pointed out, such tasks bear more stress and can be traumatic. Not all developmental tasks present the crises, however, that many writers and practitioners emphasize. Birren (1964) indicated that crises and problems are given far more attention than crisis-free situations, that people can cope successfully with crises, and that some crises present pleasurable alternatives.

Be that as it may, two complementary conclusions emerge. One is that paradigms of developmental stages and tasks are useful for a general understanding of the aging process. The other is that individual diversity and environmental variability cause many people to deviate from established stages and developmental tasks. Applicable to any paradigm of life stages is Kalish's (1975) comment about Kubler-Ross's (1969) paradigm for terminal illness (denial, anger, bargaining, depression, acceptance): "Not every person goes through each stage in the sequence presented, and people may move back and forth between stages or may even be in two stages simultaneously" (p. 94).

Change and Stability

From stage to stage over the life span many changes in individuals and their circumstances occur but stability is also evident, according to Birren (1964): "Both stability and change mark our biological organization just as they do our psychological and social organization" (p. 2). Britton and Britton (1972), acknowledging the stability, continuity, and consistency of both individuals and their environments, stressed that some of the many internal traits and external factors involved are likely to persist while others change. Among numerous variables subject to change are needs, values, interests, attitudes, emotions, goals, expectations, reference groups, roles, dependence/independence, locus of control, living location, and living arrangements.

To illustrate how changes may represent gains as well as losses and how nonchanges are often positive retentions, a sample tripartite listing is presented of losses, retentions, and gains commonly observed or experienced over Havighurst's periods of middle age (30-60) and later maturity (over 60). The counselor should remember that individuals experience these losses, retentions and gains in varying degrees.

Potential Losses	Retentions	Potential Gains
Health and strength	Cognitive capacities	Maturity, experience
Hearing and vision	Old learning	Frustration tolerance
Appearance and body image	Long-term memory	Cautiousness
Reaction time	Immediate memory	Accuracy
Psychomotor skills	Work productivity	Need for achievement
Employment	Personality traits	Responsibility, reliability
Income	Adaptability	Steady work habits
Independence, identity	Creativity	Work morale, loyalty
Sense of usefulness	Sexuality	Less supervision required
Time structure	Social awareness	Fewer job accidents
Social status	Nurturance	Lower absenteeism
Parents, spouse	Aestheticism	Lower quit rate
Children, friends	Coping mechanisms	Higher job satisfaction
Involvement (engagement)	Sense of well-being	More free time

Single items may interact with one another. Reduced reaction time and psychomotor skills may, for example, produce cautiousness and increased accuracy in performance. Various losses may combine to yield an enhanced need for achievement. Social awareness is a gain for many individuals. Other individual differences can cause shifts from one column to another. As Botwinick (1973) emphasized, "Whatever the significance of the slowing with age, the magnitude of individual differences is very great. Very many old people are quicker in responding than many young adults" (p. 177). It has often been observed that variability among older people is greater than that between older and younger people.

Changes, whether gains or losses, differ in their onset. Some are immediately evident, baldness being a common example. Other changes are unknown or unnoticed, becoming evident only as a cumulative effect, sometimes referred to as a "sleeper effect"; a heightened need for achievement represents such a change.

Changes are also affected by an individual's age cohort or people born about the same time who may differ from members of other cohorts in their socialization and consequent attitudes and values. Society as a collective of cohorts sometimes sends divergent signals, but does exert an overall influence on aging and reactions to aging to the extent that "sociogenic" is a common term for changes that occur in an individual as s/he ages: "Most of the handicaps of oldness in our society are social, conventional and imaginary" (Comfort 1976, p. 89).

Whether they are induced sociogenically, psychogenically, or simply physically, many changes cause discomfort, anxiety, or stress. Hurlock (1975) mentions four types of stress: somatic, cultural, economic, psychological. Such stresses are frequently multiple, interactive, and cumulative, resulting in an overload too great for some individuals to bear, though some people seem to be blessed with built-in circuit breakers. Fortunately, as Birren (1973) brought out, "not all changes with age are irreversible. This applies even to some of the physiological phenomena" (p. 20).

The reversibility of some changes accompanying various life stages is an example of the facts counselors should be familiar with. Realistic knowledge, as opposed to fables and fictions, can enhance counselors' understanding of aging clients and can sometimes suggest appropriate helping procedures. For example, some of the physiological phenomena referred to by Birren may be subject to reversal through biofeedback.

Counselors must avoid the popular pitfalls of lay persons and exorcise, rather than exercise, generalizations that lament losses, ignore gains, and give little regard to retentions. For example, difficulties caused by hearing loss can be lessened by use of proper hearing aids and by counselors' enunciating slowly, clearly, and in good light. Loss of involvement, whether social, psychological, or some combination, need not be interpreted as a wholesome prescription for the waning years

(Cumming & Henry 1961), but as simple description from which individuals can deviate. Cognitive capacities and personality traits persist; older people tend to be even more the way they were when younger and to call on their most durable components of intelligence. Intelligence, as stressed by Botwinick (1973), "is not a unitary quality; there are intelligences, and these vary with age in different ways" (p. 196).

Gains and retentions are evident in publications that present the myths and realities of aging. The Harris study (1975), for example, showed that many losses younger people expect to "afflict" older people either do not occur to everyone or are taken in stride. Some common myths are that older people are physically decrepit, beyond work, beyond sex, lonely and lost, and poor prospects for discussions of operations or death. The process of stereotyping older people is properly called ageism, paralleling the racism and sexism that afflict ethnic groups and women.

Kalish's (1975) summarization that "younger people often stereotype the elderly and presuppose decrements that have not really occurred" (p. 42) also reflects the unfortunate we-they phenomenon whereby younger people fail to see themselves on the same life continuum as older people. Younger people generally cannot conceive of themselves as getting very old, let alone dying. The we-they phenomenon between young and old, healthy and sick people, men and women, mainstream and minority people marks a failure of identification with human commonality and breeds prejudice, discrimination, segregation, isolation, and dehumanization.

The culmination of the mythical beliefs and prejudice to which older people are exposed is that many older persons, as products of socialization themselves, erroneously assume that losses and inadequacies are the inevitable consequences of aging. Conditioned to accept the realities of life, they may assume that many myths are realities and may experience self-fulfilling prophecies. When they do, they cease coping and succumb to a sense of helplessness (Seligman 1975). According to Rosenfeld (1977), "Most of us, to one extent or another, are guilty of teaching others helplessness" (p. 37) — a vital warning for counselors.

CAREER CHANGE

The multiplicity and complexity of developmental tasks within middle age (30-60) and later maturity (over 60) suggest the necessity to select phases of the aging process for discussion. The focus here is on career change, retirement, and death and dying.

The increased number of people changing to second and third careers can be attributed to external factors operating in society and internal factors motivating individuals. External factors tend to create involuntary career changers, those who are forced out of careers for such reasons as loss of employment through layoff or retirement, a need for additional finances, a disabling condition, or termination of marriage. Divorce or separation may free either mate for a change to a new career.

External and internal factors are largely interactive, however, and a "force-out" is often hard to distinguish from a "drop-out." The quotation marks are intended to remove any stigma from either term, for culpability need not be associated with causative outer or inner events or with change itself.

What are some of the internal factors that cause career change? Selected items from a longer list presented previously (Sinick 1977) illustrate reasons or rationalizations for people to change careers voluntarily. An initial career may turn out to be, or appear to be, inappropriate in one or more ways: ability-aspiration discrepancy, vocational interest incongruency, inadequate job satisfaction, too much or too little responsibility, insufficient variety in work content, dissatisfying features of the work context, co-worker divergencies in values and life styles. The multiple interactive nature of inner pressures and environmental presses has been succinctly discussed by Heddesheimer (1976).

Although initial careers are often inappropriate from the outset — in large measure because of the complexity of the variables involved in occupational choice — developmental changes and environmental changes contribute to career changes. Little need be said here about environmental fluctuations such as those caused by automation and computerization, mergers and acquisitions, and new occupational specializations. More germane to the developmental theme are changes in society and in individuals.

The feminist movement, early completion of families, polarization of materialism and humanism, retirement at early ages — such trends typify societal changes that may spur career changes. Changing societal trends lead to generational differences that need to be taken into account in understanding individual motivations. Each individual is to be seen as a changing figure against a changing ground.

Individual development relates to the stages and tasks and changes and the factors generating career change discussed earlier. Super's (1977) synthesis emphasized the concept of vocational maturity, "the ability to cope with the vocational or career development tasks with which one is confronted" (p. 294). Major subconcepts of vocational maturity include "planfulness" or time perspective, exploration, information, decision making, and reality orientation. Many chronologically mature clients may lack experience in these aspects of vocational maturity and can be aided by counselors.

Obstacles to Career Change

Individuals may lack vocational maturity or any one of its components. Women entering or re entering the labor market may need orientation or reorientation to the world of work. Clients often lack self-confidence in making a career change or a knowledge of the factors involved in career choice and job-seeking. Inertia holds many where they are, particularly when pension plans appear too good to relinquish.

Externally, ageist attitudes and practices among employers, despite affirmative action legislation for older workers, create artificial, arbitrary barriers that limit the hiring of qualified individuals who would like to change careers. Irrelevant or prejudicial screening procedures are frequently used, such as medical examinations, standardized tests normed on younger persons, educational credentials, and job interviews that can conceal the real reasons for rejecting older job applicants.

Although to a lesser degree than the general population, counselors also exhibit ageist attitudes (Troll & Schlossberg 1971). If they are insufficiently familiar with theories of life development and career development, they may readily apply restrictive stereotypes instead of helping older clients seek new horizons. Many counselors still subscribe to the outmoded concept of irreversibility enunciated in an early book by Ginzberg and associates (1951) but later renounced by Ginzberg (1972). Despite career investments involving education, seniority, pension contributions, and other monetary and nonmonetary variables, more and more people, including older people, have changed careers.

Avoiding ageist stereotypes, counselors must help career-change clients in assessing their motivations, external presses, overt and covert variables related to current and future careers, pertinent sociological and economic trends, and various aspects of vocational maturity. Although it is axiomatic to use clients' old skills and interests, new skills, interests, and client characteristics may require assessment, development, or simply discovery. Assessment of older clients should rely less on standardized testing than on such other indices as the interview, work history, family history, nonwork interests and activities, and functional intelligences and abilities. Clients should participate maximally in determining whether or not they need testing. If tests are used, the older person should be involved in test selection, administration, scoring, and score interpretation.

Self-confidence can be encouraged in a variety of ways, one of them being the evident confidence of the counselor in the client. Adoption of ageist attitudes can be countered by attention to the gains and retentions accompanying aging. One useful technique is to evoke the memory of successful experiences, of even minor incidents in life that may serve to increase the belief in self. Further self-confidence can be built by increasing the clients' knowledge of careers, decision making, and job-seeking.

Prejudicial attitudes and discriminatory practices on the part of employers must be constantly countered through efforts to implement and improve affirmative action legislation. The gains, retentions, and other positive attributes of older workers must be clearly translated into terms of effective job performance. To accomplish these ends, counselors, clients, and the entire community must collaborate. Career changers can sometimes get a foothold through part-time, temporary, or volunteer work.

The planfulness that Super (1977) emphasized as an important part of vocational maturity is also an important part of the counselor's role. Client and counselor should be alert to possibilities and difficulties. Entine (1977) divided both the internal and external factors affecting career change into anticipated and unanticipated factors. As Neugarten (1976) stressed, "It is the unanticipated life event . . . that is likely to represent the traumatic event" (p. 196).

RETIREMENT

Whether voluntary or involuntary, retirement may involve career change, so the information presented in the preceding section is applicable to this one. This section focuses on other aspects of retirement, but some earlier emphases are reinforced. (See Module 5 for a more in-depth discussion of retirement.)

Attitudes Toward Retirement

Although some workers look forward to retirement as a cessation of their labors, others dread retirement as tantamount to unemployment and even as a harbinger of death. Comfort (1976) speaks blunt truth for many: "Retirement is another name for dismissal and unemployment" (p. 29). So strong is the work ethic in our society that being without work is sometimes interpreted as being without worth.

Society's reverence for work, competition, speed, and youth relegates older workers and retirees particularly to second-class status. Even those who look forward to retirement seldom find what they were looking for in retirement, many not really knowing what it was. The aim of retirement has not been to benefit older employees, but to remove deadwood, functionally defined not as incompetent employees but as employees who reach an arbitrary age.

Retirement may become a state of restlessness instead of rest, largely because society has not armed retirees with rewarding activities to perform or even with a philosophy of remaining active. "Growing old gracefully" long preceded the Cumming and Henry (1961) prescription of disengagement. Although this philosophy may fit the personalities and life styles of some older persons, others eschew either social or psychological disengagement and prefer to remain actively involved in life. Retirement does not terminate one's hierarchy of needs.

Preparation for Retirement

For retirement to be rewarding, planfulness is usually necessary. Objectively the need for preretirement planning makes good sense, but subjectively people generally demonstrate strong resistance toward contemplating retirement, just as they resist thinking about death. Individuals and society are generally oriented more toward remediation than prevention; crises arise and are then dealt with — fires are put out rather than prevented. Some people rationalize this attitude as the adventure of letting things happen as they may.

Without diminishing the adventurous aspects of living, preretirement planning can widen horizons and offer new vistas. It can also minimize the operation of chance and maximize individual choice — another axiom of counseling. The developmental theme of this syllabus emphasizes deliberate planning and conscious decision making at earlier life stages in anticipation of later stages.

Deliberate planning has increasingly been recognized through the establishment of preretirement programs in both the public and the private sectors (Manion 1976; Ullmann 1976). One turning point was a broad study by the U.S. Civil Service Commission (1968) whose positive results pointed to the need for and the usefulness of such programs. Unfortunately, many programs focus on retirement income and related financial matters, with scant attention to other vital considerations.

Adjustments in Retirement

One cannot assume that having adequate retirement income — important though it is — will preclude other significant adjustments and readjustments that may be necessary in retirement. Individual roles undergo change, available time lends itself to different use, and such matters as housing and health require attention. Once the role of breadwinner is lost, a person may be held in less esteem by family and friends. Role reversal often occurs with regard to independence/dependence, children becoming predominant and sometimes patronizing. Disengagement may be acceded to as the path of least resistance.

Continued active use of time, however, offers many possibilities. If not full-time career change, part-time employment suggests itself as favorable to both employers, who save fringe benefits and gain flexibility, and older workers, whose hours can be even more flexible with "flexitime." Government agencies alone hire hundreds of thousands of part-time employees. Opportunities for temporary and volunteer work are also readily available. Time can also be productively devoted to general education, specific training, and enjoyable leisure activities.

Additional adjustments involve where to live, with whom to live, how to maintain health and safety, how to manage budgets and legal affairs, and perhaps how to be an advocate for older people. Living arrangements could be in a variety of settings, with or without family, friends, or younger people. Health check-ups, nutrition, exercise, and safety may be related to living arrangements, as may finances, lawyers, and consumerism. Consumerism is only one of numerous ways that older people can engage in activities transcending their personal benefit.

When retirement involves career change, the implications suggested in that section would again be applicable. Other relevant variables to consider include attitudes toward retirement, not just of the client alone but also of significant others. The counselor should be aware of the interactions of these attitudes. Client needs and feelings about the degree to which they wish to continue active involvement after retirement should be ascertained.

What preparation has the client made for retirement? Again the counselor has a responsibility to assist clients toward alert anticipation and responsive planning. Adjusting to retirement and to aging in general is facilitated by what social psychologists call "anticipatory socialization, the learning of a new role preparatory to actually assuming it" (Hendricks & Hendricks 1977, p. 105). The counselor's role is made easier by the gradual accommodation of many clients to various losses. Peers also experience these losses, which can be viewed within the framework of retentions and gains.

Counselors must be knowledgeable about the many ways in which retired people can use their time. If the client is looking for full-time, part-time, temporary, or volunteer work, the counselor will have to have a knowledge of employment opportunities and community agencies. Educational and leisure outlets should also be known, along with special agencies and programs in all these areas. Knowledge regarding basic life coping skills from housing and health through budgets and consumerism is needed.

Retired people disposed toward causes can benefit themselves, their peers, and society at large, for, as Comfort (1976) pointed out, "the things we individually can do to improve our own aging, and that of others, lie overwhelmingly in the sociogenic sector" (p. 13). Counselors can play a similar role: "It is our responsibility," stressed Bengtson and Manuel (1973), "to advocate, to agitate, and politicize for the programs needed by elderly people" (p. 55).

DYING AND DEATH

Death is a primary presence in everyone's life, whether consciously or unconsciously, cognitively or affectively. The pervasive role of death in relation to the developmental theme of this module is evident: "Thoughts of death are intertwined with the total pattern of personality development from the earliest years" (Mills et al. 1976, p. 5).

Attitudes toward death and dying will be discussed mainly as they are manifested in the extremity of terminal illness. Because of the high incidence of suicide among older men, there will be a brief discussion of suicide. Survivorship or bereavement will also be discussed. (See Module 5 for more detailed coverage of dying, death, and bereavement.)

Terminal Illness

People find it difficult to face the inevitability of death, especially their own. In letters and conversations, they frequently say "If I die . . ." instead of "When I die . . .". The difficulty is dramatically illustrated in the introduction to a book on gerontology (Hershey 1974) in which the author proudly asserts, "I accept the fact that I will probably die, eventually" (p. xii).

Acceptance of death, Kubler-Ross' (1969) last stage, is not a stage all dying patients reach. Her five stages of denial, anger, bargaining, depression, and acceptance, as with developmental stages in general, are subject to deviations. Most patients experiencing the imminence of death have not read books telling them the proper sequence to follow. To Kubler-Ross' credit, she subsequently on several occasions acknowledged the possibility of deviation from her initial formulation.

Formulas to explain or help understand patient attitudes and behaviors and to guide their own would be welcome to family members and to helping personnel. It is best to work with family members concurrently. The counselor who works with the terminally ill must bear in mind that they are indeed persons, even though the term "patients" may be indicative of their transitional stage and role. As individual human beings, they may avidly adopt the patient role, anxiously avoid it, or exhibit a whole host of idiosyncratic reactions. Diversity of attitude is also characteristic of the reactions of family members.

Although many patients desire to die at home, this may not always be feasible; hospices and other less institutional arrangements may be preferable and may even prolong life. Patients and families devote much thought, whether systematic or superficial, to the meaning of death. Life review has been recognized (Birren 1964; Butler & Lewis 1973) as a way of achieving Kubler-Ross's (1969) stage of acceptance and Erikson's (1963) age of ego integrity. "In reminiscence," said Moberg (1971, p. 12), "there is an attempt to see one's life as an integrated whole, thus giving it new meaning and integrating the personality."

Self-Destructive Behavior

People at any age take their own lives either through instant suicide or through such prolonged self-destruction as abuse of drugs or alcohol. Either behavior peaks during periods of identity crisis, notably adolescence, middle age, and later maturity, in Havighurst's (1972) terms. Men consistently exceed women in taking their own lives (Linden & Breed 1976). Counselors properly concerned with client self-actualization may first have to help to keep the client alive — with due respect being given the concept of "freedom to die," which ordinarily applies to euthanasia.

Counselors can gain much conceptual and practical assistance from the evolving discipline of suicidology. For example, Shneidman (1976) poses eight pairs of fables and facts to expose common misconceptions about suicide. The fables alone afford useful insights for counselors:

> Persons who talk about suicide do not commit suicide.
> Suicide happens without warning.
> Suicidal persons are fully intent on dying.
> Once a person is suicidal, he or she is suicidal forever.

Improvement following a suicidal crisis means that the suicidal risk is over.

Suicide strikes much more often among the rich, or, conversely, it occurs almost exclusively among the poor.

Suicide is inherited or runs in the family.

All suicidal individuals are mentally ill, and suicide is always the act of a psychotic person.

Literature is a seminal source of pertinent insights for direct or indirect use with self-destructive clients. A leading character in D. H. Lawrence's The Plumed Serpent observes, "It is life which is the mystery. Death is hardly mysterious in comparison." Clients who perceive no purpose in life would understand Nietzsche: "He who has a why to live can bear with almost any how."

Survivorship or Bereavement

Survivors of those who have died may or may not feel bereaved, depending on numerous variables (Hickey & Szabo 1973) such as the personal value of the one who died or perhaps unnecessary medical prolongation of dying. Reactions to someone's death are manifold, running a wide gamut from cold objectivity to intense feelings of guilt. Behavioral reactions are also influenced by social expectations within the family or in the norms and rituals of society.

Since grief is expected, the counselor who assists survivors is expected to help them work through their grief. When grief is absent, superficial, or spurious, assistance must take other approaches. In a classic article (Lindemann 1944, reprinted in Shneidman 1976), grief was divided into normal grief and morbid grief, with direct, delayed, and distorted reactions being delineated.

Attitudes and reactions toward death and dying mentioned in regard to terminal illness are relevant here. An advantage of working with dying persons and their families together is that the family can be helped to adjust to the death before it happens. Since both the dying and the living seek the meaning of life and death, they can be assisted, first together then the survivors separately, in finding at least partial answers.

Since death and dying hover over the living all through the life span, any developmental approach would suggest early sophistication on the part of both clients and counselors. Counselor expertise should include knowledge of the nuances associated with terminal illness, self-destructive behavior, and survivorship. All these situations produce idiosyncratic attitudes, cognitions, and behavioral reactions, so that broad generalizations are only simplistic guidelines.

Proposed predeath stages (Kubler-Ross 1969) are not followed by all patients, who are, above all else, individuals. Acceptance, if it is reached, can be interpreted as being based on a multitude of reactions from coping to succumbing. Multiple motivations underlie self-destructive behavior and what appears to be instant suicide is less likely a sudden event than a critical point in a poignant process. People need reasons for living, comprehensible rationales for dying, and assistance with reactions to surviving. For people well served by rationalizations or by beliefs incongruent with what the counselor believes to be true (or good or beautiful), it must be remembered — some counseling theories to the contrary notwithstanding — that shattering illusions can shatter individuals instead of helping them to live or die more happily.

Implications for Counselors

DEVELOPMENTAL STAGES, TASKS, AND CHANGES

A counselor's knowledge should include developmental stages and tasks proposed by various authorities, recognizing the deviations caused by individual differences and affected by such variables as sex, ethnic, or socioeconomic status. Over the life span, individuals display both change and stability, losses being accompanied by retentions and gains. Some losses and other changes with aging are reversible. Myths, fables, and fictions obscure the picture of the aging, who are subjected to stereotyping and other forms of ageism. Younger people often fail to see themselves on the continuum of life. Ageism breeds prejudice, discrimination, segregation, dehumanization. Some aging people themselves tend to accede to the distortions and discriminations of ageism.

CAREER CHANGE

Career change is generated by internal and external factors. More and more people are becoming career changers. Their motivations and other relevant variables require assessment, with serious consideration given the question of whether or not to change careers. Both existing and potential client characteristics are to be taken into account, with nontest assessment procedures being favored over standardized tests. Client participation in the counseling process is to be maximal and client self-confidence enhanced as necessary. Counselors should also help to counter discriminatory practices of employers.

RETIREMENT

Retirement and preretirement are affected by attitudes and attitudinal interactions. Retirement commonly requires numerous adjustments and readjustments, each individual weighing disengagement versus remaining active. For most people, preretirement planning and preparation are essential. Housing, health, finances, safety, and legal affairs are among many matters to be considered. Retired people can engage in full-time, part-time, temporary, and volunteer work or use their available time for education, leisure activities, and activism.

DYING AND DEATH

Death is present in everyone's life and everyone finds it difficult to face up to his or her own death. The terminally ill display a wide diversity of attitudes and behaviors. Counselors are well advised to work with such persons and their families together. Life review or reminiscence can help to give wholeness and meaning to life, to both the living and the dying. Self-destructive behavior occurs most frequently at points of identity crisis. Counselors can gain much conceptual and practical assistance from the discipline of suicidology. From the broader area of thanatology, counselors learn that survivors' reactions to death are influenced by such factors as personal relations, social norms, and religious beliefs and customs.

Individual/Class Activities

1. After becoming familiar with Havighurst's developmental tasks of later maturity, design a short interview (to be administered in oral or written fashion) that will evoke responses reflecting the achievement or the failure of the successful completion of these tasks.

For the age cohort 60 or over, select one person to interview from several of the following categories: retired blue collar workers (male and female), retired white collar workers (male and female), employed blue collar workers (male and female), employed white collar workers (male and female); widows; widowers; etc.

Develop a brief summary of each individual interview and report similarities and differences among groups. Provide some hypothetical explanations for these similarities and differences.

2. Review Havighurst's developmental tasks for the age group 40 to 50 years. Again, design an interview to determine the accomplishment of these tasks. Interview the same people interviewed in the preceding exercise. Compare each interview here with the results of the first interview.

Does successful completion of the tasks for later maturity depend on the successful completion of tasks in the middle years? Were these tasks particularly stressful for particular individuals? Were tasks accomplished "on-time" or "off-time"? Students should be asked to conduct interviews on their own and to share their findings with the group.

3. Invite a nurse from a hospice or a nursing home to address the topic of psychosocial needs of the older dying person. There should be discussion after the address. Of particular importance should be issues such as dependence/independence and advocacy vs. controlling behavior.

4. Recalling the discussion of potential losses, retentions, and gains covered in this unit, select 10 potential gains or retentions to comment on. List the 10 items, provide one common myth associated with each particular gain or retention and a statement that is more factually representative.

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Evaluation and Assessment

A. Written reports.
B. Oral reports.
C. Written examinations.
D. Examples pertinent to A, B, or C:
  1. If you could choose one age in life at which to remain permanently, which age would it be? Explain why you picked this age rather than others.
  2. From introspection and from interviewing at least one other person, discuss how unnecessary career change could be avoided and appropriate career change facilitated. As a further resource draw on relevant readings.
  3. What are the three or four major problems of retirement for most people? How could these problems best be avoided or minimized? Use as a resource any personal acquaintance with retirement, as well as drawing on relevant readings.
  4. Young people may have a "we-they" attitude toward older people. The healthy and living may have a we-they attitude toward the sick and dying. What can individuals and society do to foster more wholesome attitudes? Draw on relevant readings.
  5. Discuss the benefits and limitations of using the step/stage/passage theory as the conceptual framework for studying transition in aging.
  6. Are Havighurst's developmental tasks of later maturity relevant only to older people? Discuss these tasks in relation to younger, perhaps special, populations (e.g., handicapped). In your discussion of these tasks incorporate some discussion of Neugarten's "on-time, off-time" theory and how this may affect the successful completion of tasks.

MODULE III

PHYSIOLOGICAL CHANGES AND COMMON HEALTH PROBLEMS OF AGING

Alberta Macione

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Recently she has conducted research on the subjective well-being of noninstitutionalized older adults in terms of self-perception of health and mental health. She has maintained a private practice for outreach counseling of older adults. In addition, she served as consultant to various state and federally funded projects that involve alternatives to institutionalization for older adults. Triage, Inc., described in the following module, is one such agency.

Her primary responsibility is to the University of Connecticut, where she serves as assistant professor of nursing in the graduate program. Her specialties are gerontology, client assessment, and group process.

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PHYSIOLOGICAL CHANGES AND COMMON HEALTH PROBLEMS OF AGING

Rationale and Objectives

During the past 40 years, there has been considerable development of research on structural and functional changes due to or related to aging. The existence of universal changes due to biological aging as well as unique cumulative, anatomical, physiological, and psychosocial changes due to time-related pathological events has been documented.

Counselors of the aged, who are familiar with the normal changes of aging and common health-related problems, are able to function as more effective therapists. They are able to make timely and appropriate referrals to health care providers and service agencies. Counselors who have been thus prepared to deal with older adults are not incapacitated by a feeling of uselessness generated by harmful stereotypes regarding aging. The counselor needs to be cognizant of the universal needs of older adults as well as the unique needs of each aged individual. In understanding the role of multiple losses in the creation of stress, with the concomitant decreased physical capacity to respond to stress in later years, the counselor is better prepared to help the client plan for and cope with stress-producing change.

Despite the fact that most non-institutionalized older adults have one or more chronic diseases and consider health to be their primary worry, most older adults consider themselves to be in good health. It is the older adult's concern with personal health and the increased incidence of chronic diseases in this age group that are reasons for the counselor to know about problems relevant to the health of the older adult.

From the age of 60 on, individuals become more vulnerable to stress, disease, and the complications of the aging process. Particular degenerative changes and diseases increase in incidence with age. Older adults are more likely than younger adults to have multiple health problems or precipitous changes in their health status. Older adults are more predisposed than younger adults to the development of mental manifestations of their physical problems. (Kart, Metress & Metress 1978). A rapid change in mental status is the most common sign that something is wrong with the frail older adult's health (Agate 1971). While chronic diseases are frequently treated with long-term drug therapy, possible side effects of some of these drugs include temporary dizziness and confusion. When illness results in temporary disorientation in younger adults, they are considered delirious. When similar conditions appear in the elderly, they are too frequently considered to be mentally confused or senile and are expected to remain so.

Older adults as well as their counselors may incorrectly equate aging with increased sickness and pain. The older person who accepts pain and dysfunction as a part of aging may wait too long to seek health care. The counselor who expects discomfort, dysfunction, and confusion in the older client may not respond with an appropriate timely health referral.

While most older adults report that they are happy, the irreversibility and the long duration of chronic disease are potential causes for depression in older adults.

Because of possible precipitous change in health status, especially in the frail elderly, compounded with the older adult's possible acceptance of sickness as a part of aging, it is important for the counselor of older adults (as opposed to those who work with younger people) to know how to assess the client's functional capacity, physical as well as mental. The older adult's functional capacity and his/her perception of personal health are key factors in the determination of the hierarchy of his/her needs. Familiarity with commonly used tools for functional assessment of older adults is essential.

Objectives

The objectives of this module are as follows:

(1) To increase the counselor's knowledge of physiological changes and common health problems related to aging as they affect the older client.

(2) To increase the counselor's knowledge of the special role of stress in the older adult.

(3) To increase the counselor's knowledge of specific communicative adaptations to aid the therapeutic relationship with the aged client.

(4) To increase the counselor's knowledge of specific adaptations that can improve the counseling setting for the older adult.

(5) To increase the counselor's knowledge of referral systems specific to the older adult.

PHYSIOLOGICAL CHANGES OF AGING: AN OVERVIEW

Contrary to popular belief, later years can be characterized by good physical, emotional, and social health. Personal history, economic factors, and time for adaptation to stressful events are important factors that qualify the level of health maintained by an older person (Macione & Hayes 1976).

Because each person is the unique product of everything experienced in his/her life, s/he becomes increasingly unique the longer s/he lives. Behavior patterns developed over a lifetime, such as emotional outlook and personal health practices, help to determine capacity to react and adapt to stress as well as to develop attitudes and practices that foster healthy later years.

It is important to recognize that the aging process is a part of total human development. It is perhaps more important, however, to understand that the rate of aging varies with each individual and that planning for adjustment to the slow, almost imperceptible changes associated with aging is a positive response.

Judgment of the age of another individual is affected, even if at a subconscious level, on the basis of various personal criteria for aging. Rossman (1971) has advised skepticism of some criteria for judging age. Aging changes that are local may only be an indication of the individual's unique environmental exposure (e.g., wrinkling from much exposure to the sun) or genetic heritage (e.g., early familial graying or baldness).

Chronological age in itself does not produce senility, feebleness, or unproductivity. Rather, a combination of specific disease processes, an unhealthy physical and/or psychological environment, and an expected decrease in capacity to adapt to stress are the usual causes for stereotyped characteristics associated with advancing age (Macione & Hayes 1976).

Although there are many theories concerning the nature of biological aging, it has been difficult for researchers to establish facts relevant to the nature of changes of aging. There exists much controversy relevant to conclusions of research regarding changes due to aging. One major contribution to the confusion has been the difficulty of distinction between changes caused by aging and those caused by time-related pathological events (e.g., diseases such as osteoarthritis, arteriosclerosis, etc.).

Related to this confusion has been the problem of research design. In most studies of aging changes, cross-sectional methods of comparison were used instead of a longitudinal approach. Included among the threats to the validity inherent in a cross-sectional approach are: differences in environmental experiences for the different age groups and comparison with an aging population that may represent a select group of survivors. Several longitudinal studies, however, have been initiated with some results reported already (Palmore 1970, 1974).

Strehler (1962) has described four main characteristics of true aging. The aging process is: (1) universal, (2) progressive, (3) decremental, and (4) intrinsic. The process of aging begins with conception and proceeds gradually, yet irreversibly throughout the lifespan. Time-related pathological events appear with relative abruptness, frequently being amenable to treatment (i.e., stroke, heart attack, tumors, etc.).

While a great deal about aging is still unknown, several primary characteristics can be noted. Old age is characterized as a period of physiological, psychological, and social changes that are multiple, profound, and varying in intensities. While characteristics possessed prior to old age appear to modify the amount and nature of these changes, they do not account for the actual changes themselves.

Biological changes that relate to the older adult's reduced physical ability to adapt to the many changes are: loss of reserve capacities, reduced effectiveness of control mechanisms that maintain homeostasis, and the need for an increasing amount of time to recover from physical and mental stress (Goldman 1971; Macione & Hayes 1976).

Normal biological changes that occur during the later years may predispose an individual to both acute and chronic illness. Atrophy of sweat glands and subcutaneous tissue leads to decreased ability to perspire and loss of ability to regulate body temperature. Ability to adapt to cardiac or vascular stress is reduced by as much as forty percent at the age of sixty-five and continues to decrease as one grows older.

In the digestive system changes that occur interfere with food intake and utilization. The teeth become worn or possibly lost. Taste buds degenerate and as much as eighty percent of the taste function may be lost. Digestive enzymes and gastric acids decrease qualitatively and quantitatively, leading to less efficient digestion and absorption of foods and essential minerals. Digestive tract muscles weaken and shrink with the result that bowel function may become sluggish.

These selected examples of expected changes during later life provide potential reasons for the changes in blood pressure, decreased appetite, digestion and bowel function disorders, etc., that form the bases for many of the health complaints of older people.

Brain cell degeneration and loss, combined with blood vessel changes, present the cause for possible behavioral changes, diminished emotional responses, and lessened adaptability to the environment (Macione & Hayes 1976).

Nervous System

Aging in the nervous system is characterized by a steady loss of neurons and a progressive decrease in the weight of the brain. There is also a significant reduction in cerebral blood flow and brain metabolism. Research has demonstrated, although not consistently, a direct correlation between these changes (amount of decrement of cells, brain weight, and metabolism), and the patient's age or behavior (Smith & Sethi 1975; Wang 1977). Counselors should remember, however, that in some cases individuals with similar number of cells, brain weight, or metabolism may manifest no signs of intellectual deterioration or they may be totally incapacitated. Many variables other than those associated with physiological age changes (e.g., sex, race, socio-economic background, and education) affect cognition and its assessment (Botwinick & Thompson 1966). Alteration of the sleep/wakefulness ratio and the ability to regulate body temperature also suggest modification of specific brain functions.

Reflexes

A significant age-related change is the amount of time needed to receive and respond to stimuli. There have been numerous studies regarding the speed of motor nerve conduction (reaction time). While there has been variation among individual studies, it has been sufficiently demonstrated that young adults have a faster reaction time than older adults (Jarvik & Cohen 1973). This speed decreases more rapidly, especially after the fourth and fifth decades. By ages 80 to 90, reaction time may have decreased by 15 percent, with men having greater decreases in reaction time than women (Goldman 1971). Researchers have suggested that the longer total time required by an older adult to respond to a stimulus is a reflection of the reduced functioning of the central nervous system (Botwinick & Thompson 1966; Weiss 1965). It has also been found that in older adults visual reaction time is slightly longer than auditory reaction time (Birren 1964). Jarvik and Cohen (1973) suggest that the differential decline of visual and auditory reaction time in older adults compared to younger adults, along with the observed slowing in both premotor and motor segments, may be due to changes in the interneurons. The literature suggests that changes in the nervous system leading to this slowing are not under the voluntary control of the individual (Botwinick 1965).

It was also found that within the older age group there is a differential decline of visual and auditory reaction times in older compared to younger adults. Research results suggest that exercise, genetics, nutrition, and other variables may influence the rate of decline of reaction time (Jarvik & Cohen 1973). While brain cells do not regenerate, the existing healthy brain tissue, in a supportive environment, may be able to reorganize and continue functioning.

Vision

As adults age their senses decline. It has been found that 15-18 percent of the elderly have poor vision (Kornzweig 1971). The majority of older adults have good to adequate visual acuity to age 90 or beyond. Decrease in visual acuity is partially the result of cumulative change in the transparent parts of the eye (the cornea and the lens). The actual amount of loss varies considerably. There is also an aging-related loss in the extent of the visual fields (peripheral vision), a decrease in the speed of dark adaptation, an elevation in the minimal threshold of light perception, and a greater proportion of loss of visual acuity in dim light. Changes in the lens of the eye and its muscles impair visual acuity, especially at close range (Herr 1976).

Older adults need a longer period of time to react to what they see, take longer to adapt to night vision, and do not see as well as younger adults, especially in dim light. Decreased visual fields may result in more cautious or hesitant behavior in activities such as driving while decreased adaptation to night vision may even preclude evening activities outside the home unless there is someone to assist with transportation.

Hearing

Another sense that is especially vulnerable to age changes is auditory acuity. Approximately 29 percent of people over the age of 65 have some difficulty with hearing (National Health Survey 1967). While there is an overall decrease in auditory acuity with age, there is also a selective loss of hearing for the higher pitches. While acoustic trauma, genetic factors, and circulatory impairment are contributing factors, the selective loss of the high frequencies is usually due to sensorineural changes — loss of hair cells of the organ of corti (a part of the inner ear) — and is not reversible (Ruben 1971). The general loss of volume (loudness) sensitivity is caused by problems within the middle ear, such as ossification of the joints of the bones in the middle ear, and can be helped by a hearing aid, surgery, or both. A large amount of hearing loss in the aged is related to neurological deficits, the inability of the central nervous system to understand the information that is less perfectly transmitted by the ear (Ruben 1971). When the spoken message is more complex or is presented with background noise, it is more difficult for the older adult to understand. Older adults with such hearing deficits need increased amounts of time to understand and respond to the spoken word, especially if spoken rapidly. Shouting or even speaking more loudly does not aid the older adult with sensorineural deficits of auditory acuity. Shouting raises the pitch of the voice, frequently into the range that is lost. Many older adults unconsciously learn to lip-read when they experience decreased auditory acuity. Speaking slowly and directly toward the listener with a deeper pitch of voice will increase acuity in older adults with sensorineural and neurological hearing deficits. Repeating a message with a simpler choice of vocabulary and elimination of background noise may also help.

Behavior Disorders

In addition to sensory decrement, behavioral changes may occasionally be induced by aging changes within the neurological system. A constellation of behavior patterns commonly described as "senile" is not a natural concomitant of age. It is emphasized that "senile" in medical terminology (i.e., senile freckles) is used to describe a change associated with aging, while lay people generally associate the term only with behavior typical of senile dementia.

"Senile" behavior stems from a combination of pathological conditions of the brain, environmental stress, or both (Jarvik & Cohen 1973, Butler 1971). The actual clinical diagnosis of senile dementia and its related behavior patterns occurs in a relatively small percentage of the aging population and has been shown, in some cases, to be amenable to therapeutic intervention (Butler 1973).

Behavioral disorders are broadly classified as coming from two causes, organic and functional. Functional disorders appear to be emotional in origin, being related to personality and life experiences. Organic brain syndrome is a basic mental condition characteristically resulting from diffuse impairment of brain tissue function. The primary characteristics of organic brain syndrome are disturbance and impairment of memory, impairment of intellectual function, impairment of judgment, impairment of orientation (Wang 1977), and labile or shallow effect (Butler 1973). While all these characteristics may not be present at the same time or to the same degree, they represent basic elements of organic brain disorder, especially in advanced states. These characteristic signs may range in severity from barely perceptible changes to profound loss of functioning. In acute brain syndrome, signs may be reversed. In chronic brain syndrome they are irreversible, with gradual or precipitous decline of mental abilities. Early cognitive warning characteristics of organic brain syndromes (Butler 1973) include:

decreased IQ scores
slowed stream of thought
impoverishment of ideas
decreased abstraction (increased concreteness)
decrement in recent memory
difficulty in maintaining attention
perseveration
confabulation
increasingly impaired comprehension

Early behavioral and affective characteristics of organic brain syndrome may include:

reduced responsiveness
progressive withdrawal
decreased direct, immediate affective expression
inappropriate affect
labile affect
tendency under stress to "disintegrate"

Later behavior and affective characteristics include:

impaired orientation
impaired comprehension

impaired judgment
inappropriate behavior
confusion

It is to be emphasized that it is not only the organic dysfunction, but also the individual's prior personality constellation, pattern of learned responses, and the environmental situation that together determine the kind and severity of symptoms that appear (Wang 1977; Busse & Pfeiffer 1977). Personal reaction to change in intellectual capacity is highly individual, especially in the earlier stages of decline. It is not uncommon to find an older adult who has successfully disguised his/her intellectual deficits with a social facade that appears normal until more careful examination discloses a significant decline in memory and orientation.

Some of the organic disorders associated with aging are Alzheimer's Disease, Pick's Disease, cerebral vascular accidents (strokes), and cerebral arteriosclerosis. Alzheimer's Disease, Pick's Disease and senile dementia are associated with degenerative brain tissue changes that result in deteriorated behavior. Cerebral vascular accidents (CVAs) and cerebral arteriosclerosis affect the brain by denying the affected tissue the oxygen required to sustain proper physiological function. CVAs usually involve local areas of the brain and are of sudden onset. The behavior changed by the stroke will be dependent upon the area of the brain affected as well as psychological adjustment resultant from any physical or mental deficits caused by the stroke. After a stroke, a person may experience symptoms varying from muscular weakness to paralysis of specifically limited areas of the body. Cerebral arteriosclerosis causes more diffuse tissue damage than CVAs and occurs over an extended period of time.

Stress

There are aging changes in almost every organ system, ranging from general demineralization of the skeleton through respiratory, cardiovascular, neurological, integumental, gastrointestinal, excretory, and urogenital changes. Jarvik and Cohen (1973), Goldman (1971), Kart, et al. (1978), and many others have detailed these changes. What appears to be one of the most important physiological changes of aging, especially as it relates to the adaptation and subjective well-being of the older adult, is less efficient mechanisms of homeostasis (Exton-Smith & Windsor 1971; Jarvik & Cohen 1973). Impaired homeostatic mechanisms are evidenced through a decreased rate of adjustment to various stimuli when placed under stress, either psychological or physical. Gutman (1970) and Comfort (1970) have discussed nervous-hormonal adjustment mechanisms and general homeostasis, respectively. It has been proposed that age changes are clearly shown only when the individual is stressed to maximum performance (Shock 1967).

In the absence of stress, body temperature is maintained within normal limits in the older adult; but lowered body temperature is easily induced by exposure to moderate degrees of cold, by infection, and by drugs. The reserve capacity of the tissues is impaired, making undesired drug reactions that have more drastic immediate effects as well as more serious long-term effects. Kahn (1971) has discussed the older adult's vulnerability to effects of psychological stress, with some old people manifesting almost total dementia as an acute reaction to a severe stress such as death of spouse. Sensory deprivation is another stress that can foster behavior changes in people of all ages, but becomes more apparent in the aged.

Lowenthal and Chiriboga (1973) have provided an excellent review of social stresses and their effect on adaptation, while Macione (1978) has discussed various stresses (including health) and their relation to subjective well-being. Decreased health status and mental ability, a change in residence, change in health of spouse, death of spouse, change in financial status, retirement, and many other factors have been found to be stressors. The presence of old friends or a confidant has been found to mitigate social stresses accompanying the aging process.

HEALTH RELATED PROBLEMS OF THE AGED

Musculo-skeletal

Change in motor functioning may be due to changes in the neurological system or in the musculoskeletal system. Regarding motor skills, general weakness is a frequent complaint in the elderly. Weakness may represent part of the aging process itself. The physical strength of a young adult diminishes as s/he ages, concomitant with some replacement of muscle substance by fat in the older adult (Goldman 1971). Weakness may also result from acute or chronic systemic illness or from a pathologic process in the nervous system. It is found that active exercise increases the motor power and repetitive exercise improves motor skill by improving the efficiency with which a task is performed (Tobis 1971).

While all older people have joints with degenerative changes, not all complain of pain. Some do not complain because of lack of any gain through complaint. Some older people may complain more readily because of other existing complaints such as loneliness, depression, bereavement, or even resentment of the aging process itself. In short, it should be understood by the counselor that the complaint of pain, even though real, may be more of a reflection of other problems of the older adult.

Nutrition

The older adult's nutritional needs are difficult to isolate because of the synergistic effect of physiological, psychological, and socio-economic changes concomitant with aging. The interaction of personal and environmental factors such as health, feeling of well-being, low income, loneliness, life-style, and availability of services to meet physical, social, and emotional needs tends to have as much effect on an older person's nutritional status as his/her own body's efficiency in digesting, absorbing, and utilizing the food that is eaten (Berger 1976; Mayer 1974).

With the decreased secretion of digestive juices and enzymes, there is more limited availability of the nutrients in food for metabolism as they pass through the digestive system. As motility of the digestive and excretory systems is reduced, there is frequently a limited intake of high bulk foods that provide valuable nutrients and help maintain motility of the intestines. Foods with bulk may not be eaten out of lack of nutritional education or difficulty in chewing them.

The loss of teeth, compounded by lack of replacement of dentures that fit properly, dryness of the mouth from decreased secretion of saliva, and diminished acuity of the sense of taste and smell, may decrease the variety of food the older adult selects. "Fast foods" that are soft, sweet, and usually high in calories are often preferred because of the minimum of preparation and because they are easy to eat while providing some flavor, since taste buds do remain sensitive to sweetness.

While lifelong eating habits may persist, caloric needs of the aging decrease as the level of activity diminishes. Obesity thus presents a serious problem to older adults because of its association with and perhaps predisposition to diabetes, atherosclerosis, and hypertension. In a study of adults over age 50, more than 70 percent of the women and almost 85 percent of the men were found to be obese (Berger 1976). Even though obesity may be a problem, nutritionists generally agree that the diets of the elderly are often nutritionally inadequate and that this adversely affects their health (Krehl 1974). This consensus that malnutrition in the aged is common, has been supported by research (Ten State Survey 1971). Dreizen (1974) has described the clinical manifestations of malnutrition. The earliest evidence of malnutrition in the elderly is a conglomerate of nonspecific complaints that include: anxiety, backache, depression, headache, fatigue, insomnia, irritability, lassitude, muscle weakness, nervousness, palpitation, confusion, abdominal discomfort, dyspepsia, paresthesias, and poor concentration. Dreizen further reported that the pattern of predominance and the constellation of the symptoms may vary from client to client and for the same client at different times. If the nutritional deficit is prolonged, depleted tissues are destroyed and nutritional deficiency lesions and disease status appear.

Inappropriate/Unprescribed Drug Use

As adults age and become more concerned with their health, they tend to become susceptible to advice regarding drugs and their effects. Advertisements promote the frequent use of laxatives, antacids, aspirin, vitamins and minerals, and sedatives. Use of over-the-counter drugs such as these may create adverse drug reactions, adverse interactions with prescribed drugs, and dependency or habit formation. Self-prescribed drugs may interfere with actions of drugs ordered for a specific disorder. Few drugs are prescribed for a lifetime in the same amount because of changing physiological needs.

Older adults may be influenced by advice of friends who may have experienced successful treatment with a particular drug. Symptoms may appear similar but specific cause, along with an older adult's individual unique constellation of physiological changes and diseases and the consumption of other drugs, necessitate individual attention from the doctor who will choose the specific drug prescription. Drugs kept for years on the shelf deteriorate and may change in chemical composition, becoming ineffective or even harmful. Unlabeled drug containers or those with very small print may be the inadvertent cause of inappropriate or unprescribed drug use.

Another problem involving drug use has been increasing in recent years. Pascarelli (1974) has documented the increasing number of elderly who have entered treatment for drug dependence and abuse, stating that isolation, poverty, physical disabilities, and low status subject older persons to stress and may predispose them to drug abuse. The differences in patterns of abuse in the elderly relate to the complex interaction of medical, psychiatric, environmental, and socio-economic factors (Pascarelli 1972). During treatment of elderly drugabuse, special problems are often revealed such as poor housing conditions, poor general health, chronic lung disease, and resistance to detoxification because of decreased tolerance to the physiologic changes that accompany lowered opiate dosage (Pascarelli 1972, 1974).

A large number of elderly receive a variety of legally prescribed drugs, creating an age-related hazard because of the sheer quantity of drugs that are prescribed (Wiersum 1974). Of the 21 most frequently prescribed drugs, 12 were found to be psychotropic or psychoactive substances (Task Force on Prescription Drugs 1971). While it is difficult to determine how many elderly receiving prescribed drugs are drug dependent, exposure to numbers of psychoactive drugs increases the chance of problems occurring, especially in the individual with demonstrated marginal mental compensation (Pascarelli 1974).

Alcoholism

Alcoholism is another form of drug abuse found in the older adult. Alcoholism is considered the nation's primary drug problem (Report of the National Commission on Marihuana and Drug Abuse 1973). In the isolated elderly the incidence of alcoholism is extremely high (Pascarelli 1974). Zimberg (1974) and Shropshire (1975) have noted the pervasiveness and importance of this illness. There are two types of older alcoholics (Zimberg 1974): those who have a long history of alcohol abuse and who continue drinking excessively into their later years and those who are reacting to one or more of the stresses of aging (loss of job or spouse, retirement, loneliness, etc.) and begin drunking in old age.

The prognosis is good for the second type if the stressful circumstances are alleviated and no complicating factors such as organic brain syndrome and associated depression or paranoia are involved (Pascarelli 1974). Even though it might be expected that the chronic older alcoholic might be extremely resistant to treatment, Zimberg (1974) has reported success with both types of alcoholics responding readily to a therapeutic regimen.

Alcoholism in older adults may involve vitamin and protein deficiencies, liver dysfunction, and bone demineralization. There may also be impairment of intellectual functioning and personality deterioration. This may compound difficulties for those with existing impairments from arteriosclerosis and organic brain syndrome.

Despite the seriousness of the consequences and the pervasiveness of this disease among the elderly, Shropshire (1975) has identified in the helping professions, a strong negative attitude toward the alcoholic, as well as disinterest toward alcoholism as an illness.

Related to this problem of attitude toward the alcoholic is personal definition of what constitutes alcoholism. Zimberg (1974) has based his definition not on the amount or frequency of alcohol consumption, but on whether the consumption of alcohol causes or is related to problems with family, health, employment, finances, or the law. If the individual's drinking causes problems in any of these areas and s/he is either unwilling or unable to change his/her drinking habits to eliminate the problems, s/he is an alcoholic.

The counselor's attitude toward drinking will obviously affect his/her approach to the client who is an alcoholic. It is important for counselors to identify their own attitudes toward drinking and alcoholics.

Iatrogenic Disorders

While it is generally thought that the use of prescribed drugs is commonplace, expected, and without risk (Brady 1973), it is not uncommon to have iatrogenic disorders in the elderly (Exton-Smith 1971, Hurwitz 1973). Adverse reactions to drugs are a serious health problem for the aged. Three to five percent of all hospital admissions in general are a consequence of adverse drug reactions, and proportionately more drug-induced illnesses lead to hospitalization for clients over age 61 than for those under 61 (Caranasos et al. 1974). Changes in behavior and mental status in the older adult are too frequently attributed to the client's age, senility, or a functional disorder (e.g., depression), and an underlying adverse drug reaction can go unrecognized (Kayne 1976).

The counselor should be aware that a change in mental status or the sudden appearance of mental symptoms may be due to conscientiously prescribed and administered drugs. For example, many tranquilizers, while prescribed to reduce anxiety, may produce depression. Steroids may produce euphoria when they are used in large doses and may cause depression when they are discontinued or withdrawn abruptly. Because kidney and liver function may be impaired in the elderly, many tranquilizers and sleeping medications are not broken down and excreted from the body as they are in younger, healthier persons. The accumulation of these drugs within the body can cause an abnormal physical slowing of speed and coordination to the point of coma or even death. Some older adults react to the exaggerated slowing with fear and depression, thinking that they are rapidly failing. Some psychotropic drugs can cause tardive dyskinesia, which is characterized by slow, rhythmic, involuntary movements of the face and extremities, chewing movements, lip-pursing, eye-blinking, difficulty in swallowing, or spastic neck-stiffening. While the potential dangers, complications, and side effects of drugs can range from merely annoying symptoms, such as dryness of the mouth, to more dangerous ones, such as low blood pressure and fainting, many physicians do not take the time to inform their patients of these possible effects, especially those who are a little slower or have difficulty hearing. The client should know why and what drugs are being taken as well as the expected and unexpected effects of the drug (Macione & Hayes 1976). Similarly, so should the counselor. Drug containers should be labeled with the drug name, dosage, date, and directions on how and when to take the medication. Color coding drug containers may be helpful to older adults with visual impairment.

Sexual Problems

Another health-related concern in older adults relates to sexual disinterest and dysfunctioning. Masters and Johnson (1966) have shown that the capacity for a full sexual response is not lost during aging, in either men or women. Pfeiffer et al (1972) have found in a study of men and women aged 46 to 71, that sex continued to play an important role in the lives of most individuals as they aged. Although the sexual activity in older men appeared to be greater than in women, the difference was found to be due to availability of a sexually active partner. Newman and Nicholas (1960) have reported that elderly people in reasonably good health, whose partners also are healthy, can continue to be sexually active in their seventh, eighth, and even ninth decades. In older women, occasionally an estrogen deficiency may cause thinning, cracking, and inflammation as well as decreased lubrication of the vagina that can cause considerable discomfort or pain. This condition can be eliminated through prescribed use of sex steroids.

Sexual expression of older women is further restricted by the biological limits placed on men, which include reduced sexual interest, loss of potency, physical illness, and a shorter life expectancy (Weg 1976). The most important factor determining the level of sexual activity in aging men is the level of sexual interest and activity earlier in life (Weg 1976)

If normal aging leaves older men and women with a continued active interest and capacity for sexual response, what are the biological factors that lead to decreased interest, impotence, and dysfunction? They tend to be the same factors that affect sexuality at any age. About 90% of the cases of impotence in the older population are psychogenic, while the other 10% are organic (Kent 1975).

Psychogenic impotence is characteristically periodic and selective (Kent 1975). With psychogenic impotence an older man may attain an erection and function sexually under the influence of certain drugs or with a new partner). In psychogenic impotence, it is common to be capable of masturbation and erections while sleeping. Cancer and other debilitating diseases often cause long-term impotence that is beyond the control of the individual. Urinary prostate infections may also produce temporary impotence or dysfunction until the infection is cleared. While there are various forms of prostate surgery, only total removal (prostatectomy) causes impotence (Kent 1975).

The most common organic cause of impotence is diabetes mellitus. About 50 percent of male diabetics become impotent before age 60 and the incidence of impotence increases in the later years. While potency decreases gradually in diabetics, sexual desire seldom declines with potency. In many diabetic clients sexual desire continues after many years of impotence.

Weg (1976) reports other causes of organic impotence and dysfunction: use of drugs such as alcohol, marijuana, and certain tranquilizers (e.g., chlorpromazine and reserpine); overeating and obesity; and the interaction of stress, hormonal activity, general health, and aging.

Refer to Module IV for a discussion of the psychological factors in sexual dysfunction in aging.

Implications for Counselors

STRATEGIES FOR COUNSELING OLDER ADULTS

Counseling can be very effective with older adults. While certain changes in the communicative process and environment of the counseling setting relate to the changed physiology of the older adult, there are also a number of modifications of the counseling strategy that facilitate therapy. Some suggestions of Busse and Pfeiffer (1977) include: taking a more active, explorative role on the part of the counselor; establishing clearcut, limited goals for therapy; placing a greater focus on the here-and-now of the client's life; touching the client with either a handshake or a hand placed supportively on shoulder or arm; and encouraging the client to reacquire or reactivate other real-life interactions and relationships.

The most significant physiological change that distinguishes older adults from younger adults is the decreased capacity to tolerate physical and/or mental stress due to decreased reserve capacities. It is felt by this author that decreased capacity to tolerate stress should also be addressed by the counselor of the aged. Past experiences in private practice with the aged have proven that when indicated, a problem solving approach using crisis intervention methods is successful with the aged, especially those whose physical and/or mental capacity may be compromised.

ASSESSMENT INSTRUMENTS FOR FUNCTIONAL PHYSICAL AND MENTAL CAPACITY

The counselor should be familiar with instruments commonly used to assess the functional capacities of the older adult, both for initial baseline information and for establishing whether changes have occurred over a period of time. Lawton (1973), Remnet (1976), and Macione (1978) have reviewed instruments used for assessing: physical health; physical self-care; instrumental activities of daily living; mental status, social roles, and activities; attitudes; morale; life satisfaction; and psychiatric status.

Assessment insures that all areas of functioning are considered when treating the client. It helps the counselor look at potentially important assets as well as liabilities.

It is important to remember that the pattern of assets and deficits may be more significant than any specific disability.

ALTERNATIVES TO TRADITIONAL THERAPEUTIC SETTINGS

While counseling traditionally has been accomplished in an office within a clinic or private dwelling, there have been some successful innovations to therapeutic settings for older adults who may have decreased mobility. One research project for older adults, Triage, has attempted to measure the effects of alternatives to institutionalization of the older adult (Quinn 1975, Macione 1978). Among the referral services provided by Triage, is a Counseling Outreach Program for clients incapacitated with severely restricted mobility. Travel to an office for such clients would create a stress that might impede or even completely negate any therapeutic effect from counseling. On the basis of stress and inconvenience of traveling to the counselor's office, many of the clients in Project Triage initially refused counseling until they were informed that these services could be provided within their own homes. Results at Triage have been successful. Older clients are now being counseled in convalescent homes, hospitals, and rehabilitation settings.

ADAPTATIONS TO TRADITIONAL THERAPEUTIC SETTING

Specific adaptations of the counselor's office can be used to enable the older adult to better cope with his/her impairments. Suggestions include:

Provide adequate lighting at all times but avoid bright glare.

Avoid highly polished floors which may be slippery and scatter rugs that are not tacked down.

Have a phone that is available for client's use, equipped with a special dial that has enlarged numbers or volume regulation.

Have large clocks and calendars in the office which are more readable or help provide orientation.

Have an office setting that has few or no steps that the client has to negotiate.

If it is known that the client has difficulty with mobility, be sure s/he has assistance in negotiating the entrance to the building and any stairs. Ramps are most accommodating but not always practical in a small, private office.

Provide a firm chair with a straight back for the client. Soft deep-seated chairs are not as comfortable for clients with back pain. Deep-seated chairs are difficult for many older clients to maneuver in and out of because of decreased muscular strength and control in the smaller muscles of the legs.

Allow clients with rheumatoid disease freedom to move about frequently, as sitting in one position for long periods may be uncomfortable if not painful.

Provide a room temperature that is well within the comfort zone for warmth as older adults are more prone to feeling cold because of decreased fat beneath the skin. An uncomfortably cold room temperature may be a distracting factor that can effectively hinder the communication process.

ALTERNATIVES TO TRADITIONAL COMMUNICATION STYLE

Specific techniques related to the changed physiology and health of the older adult can be used by the counselor in order to function in a more effective capacity as therapist of the elderly. These adaptations in communicative techniques can be utilized, when appropriate, to enable the older adult to better compensate for visual, auditory, or motor ability impairments.

Be aware of the client's hearing; if it is impaired, speak clearly and as directly into the good ear as possible.

Face the client directly when speaking.

Do not cover your mouth when speaking. This enables a person with a hearing difficulty to use lip-reading.

Encourage a client with auditory impairment to learn to lip-read if s/he does not already.

Do not smoke or chew gum when speaking to the client who has hearing deficits.

Keep the counseling office free from extraneous noise from sources such as radios.

Speak slowly using simple phrases, and give ample time for reply to questions.

Do not shout but speak in low tones.

If the client has a hearing aid that appears not to be functioning correctly, check to see if the microphone portion of the instrument has inadvertently been covered up or not turned up sufficiently.

When a person is completely deaf, use written communication, writing clearly in large letters. Keep a large pad and black felt tip pen (for writing in bold letters) nearby.

HEALTH REFERRALS AND AVAILABLE SERVICES

Use of timely appropriate health referrals and available health-related services can effect a reduced stress level in the older adult.

1. Counselors should get to know local physicians and their specializations. It is especially useful to know those physicians that are exceptionally accommodating to the older client. Have lists available to give to clients when they need to be referred. It is useful to establish good rapport with local physicians to enable better consultative processes regarding client changes in behavior and effects of medication.

2. Counselors should be familiar with available supportive services for older adults. Many communities provide free voluntary transportation for their older adults. Among the many services that may be available within a community are chore services, companionship services, foster care services, reduced prices for medications at drug stores, meals-on-wheels, homemaker and health aid services, health support services, mental health centers, public health nurses, volunteer visitors, hot-lines, and telephone reassurance services for those with failing health.

The counselor should also be familiar with community facilities that provide continuity of care, including local convalescent homes, adult day care centers, and senior citizen group activities.

CLIENT ADVOCACY FOR THE ELDERLY

With the decreased capacity to adapt to stress at a stage in life when the stresses are many, the older adult may occasionally need an advocate. Advocacy includes the use of all means at the counselor's disposal, including direct action, to effectively represent the needs and grievances of older adults.

Independence and assertiveness are ideal goals that may not always be realistic, especially for the older adult whose physical and/or mental capacities may be too severely compromised. The elderly need advocates who understand their needs, fears, and stresses and can help the individual to cope with these.

Once some of the sources of stress are removed, the older adult may be capable of functioning in a more independent capacity. Early intervention by a qualified counselor may be the key to preventing crises that may diminish the quality and length of later life.

Individual/Class Activities

Activity 1: Field Trip

Purpose: To provide for observation and experience in communicating with older adults across the continuum of health and physiological functioning.

Recommended Sites: Day care centers for the elderly; outpatient and mental health clinics for the elderly; outreach programs; convalescent homes; hospitals; rehabilitation centers; senior citizen centers, etc.

Process: Before leaving for the sites students should be asked to observe the following:

1. the actual type of impairments that older adults may experience
2. the degree of impairment typically associated with the level of care provided by an institution
3. the differences in coping mechanisms in individuals with similar disabilities
4. the mental health of older clients with various impairments.

Activity 2: Simulation Exercises

Purpose: To increase the student's awareness of various individual decreased capacities as well as multiple decreased capacities; to experience simulated impairment with normal activities of older adults; to experience methods of coping with impairment; and to compare coping mechanisms for multiple impairments vs. single impairments.

Group Size: Small-large

Time Required: 45-120 minutes (maximum) for all tasks assigned

Materials: Old eyeglasses with lenses scratched or vasoline smeared on them, cotton balls or ear plugs, Ace bandages, $2.00 change for each student.

Simulations:

Decreased visual acuity is simulated by students wearing glasses with scratched lenses or with vasoline smeared on good lenses.

Decreased auditory acuity is simulated by students placing cotton balls or ear plugs in their ears.

Decreased mobility is simulated by placing Ace bandages over knees, elbows, or finger joints to decrease joint mobility.

Multiple decreased capacities can be simulated by combining any of the above.

Task Assignments for "Impaired Students:"

1. Students will walk up and down 4 flights of stairs.
2. Students will walk to the nearest snack shop and after consuming a snack will pay for their bill with their change.
3. Students will take a bus to a short destination and then return by bus. All students will return at the same time. No one is allowed to wear a watch (to introduce an additional stress factor and increase the possibility of social interaction).

Process: The following are suggested questions for processing the assigned tasks:

1. How did you feel about these experiences?
2. How do you feel about older people with similar types of impairments?
3. How have you changed your attitude toward older people?
4. What are some of the coping mechanisms you developed to compensate for your impairments?

Activity 3: Role Play

Purpose: To make students aware of:

1. how the counselor feels in dealing with clients who have various decreased capacities
2. how to be more effective as a therapist with older adults
3. how the older client feels in experiencing multiple stresses and decreased capacities and therapists who are not understanding of these disabilities

Group Size: Groups of 3 persons (in triads the third person is the observer/recorder).

Time Required: 15-30 minutes for each session

Materials: Glasses with scratched lenses or vasoline smeared on them; cotton balls or ear plugs

Physical Setting: A room large enough to permit small group interaction without distracting one another

Task Assignment:

Have all students in the room count off by 3's. During the 1st counseling session, all 1's will be the client, 2's will be counselors and 3's will be observers and recorders of the counseling process. During the second and third sessions, students will exchange roles until all have had an opportunity to be the client, counselor, and observer/recorder. During each counseling session, the instructor will assign different roles to the new client and counselor.

Suggestions for Roles for Client:

An older adult with: hearing impairment as simulated in activity #2, visual impairment as simulated in activity #2, or visual and hearing impairments as simulated in activity #2.

Suggestions for Roles for Counselor:

A counselor who demonstrates that s/he lacks insight into decreased physical ability of client (diminished joint mobility, decreased senses of energy, impaired vision, hearing, etc.). that s/he is rushed and impatient, or that s/he compensates for the client's impairments.

Process:

Upon completion of the three counseling sessions, the observer/recorder will discuss the behaviors and processes observed. The clients and counselors can discuss how they felt during the role playing.

Questions that can be raised are: How did you feel when the counselor was rushed or impatient? What kinds of behaviors did the counselor demonstrate that made you feel better or worse?

Activity 4: Guest speakers may be invited to speak to the class on topics of special interest.

Suggestions for topics are:

1. Physicians may present topics on psychotropic drugs used with the elderly.
2. Various service providers may discuss their roles with the elderly.
3. Gray Panther members may discuss how the counselor may act as an advocate for the elderly in relation to health at the state and federal level.

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GLOSSARY

Acoustic (trauma)	Pertaining to sound or to the sense of hearing.
Adverse (drug reaction)	Having the opposite effect. An unfavorable or harmful effect.
Alzheimer's disease	Presenile dementia with degeneration of small blood vessels of the brain. Symptoms are those of organic brain disease.
Arteriosclerosis	A degeneration and hardening of the walls of arteries, capillaries, or veins, due to chronic inflammation. Symptoms may include high blood pressure, paleness, digestive disturbances, fatigue, chest pain, cramps in calves and legs, and blue discoloration of feet.
Atrophy	A wasting of a part. A shrinking.
Auditory	Pertaining to the sense of hearing.
Cerebral Vascular Accident (CVA)	A stroke. A rupturing of a blood vessel in the brain.
Cross-sectional (design)	A design in which data is collected once for subjects of representative age samples.
Dyspepsia	Imperfect digestion. Not a disease in itself, but a symptom of other diseases.
Homeostasis	State of equilibrium of the internal environment. The state of relative constancy of the body fluids (blood, lymph, tissue fluid) as to their chemical and physical properties.
Iatrogenic	Relating to an abnormal state or condition produced by the physician in a patient by inadvertent or erroneous treatment (e.g., through an unexpected adverse reaction to a drug).
Insomnia	Chronic inability to sleep, or sleep is prematurely ended or interrupted by periods of wakefulness.
Interneuron	A nerve cell that comes between a receptor or sensory neuron and a motor neuron.
Lassitude	Weariness, exhaustion.
Local (age changes)	Limited to one place or part.
Longitudinal (design)	A design in which a number of individuals are followed over a period of time, collecting data on the same individuals, to study changes over time.
Mental Compromise	Laying open to danger because of mental dysfunction.

Motility	Capability of moving spontaneously.
Neurological	Pertaining to the study of nerves or disease of nerves.
Osteoarthritis	A degenerative joint disease, especially involving weight bearing joints. Characterized by destruction of the cartilage that articulates within the joint, overgrowth of bone, and impaired ability to bend the joint.
Palpitation	Rapid, violent throbbing or fluttering of the heart.
Paresthesia	Abnormal sensation without objective cause (e.g., numbness, pricking, etc.).
Pick's Disease	A progressive dementia. Symptoms are those of organic brain disease.
Psychoactive	A drug or chemical that has a pronounced or specific effect on the mind.
Psychotropic	Having an altering effect of the mind, e.g., tranquilizers, hallucinogens, etc.
Reserve Capacity	The ability to reserve for future use the maintenance of ideal physical homeostatic mechanisms (i.e., the body might have alkali available to neutralize an over secretion of acid to help maintain an optimum P.H.).
Subcutaneous	Beneath the skin.
Synergistic	Having the property of simultaneous action of separate factors, which together, have greater total effect than the sum of their individual effects.
Systemic (illness)	Pertaining to the whole body rather than to one of its parts. A disease that acts on the body as a whole.
Tardive Dyskinesia	An involuntary movement occurring as an undesired effect of therapy with certain psychotropic drugs, esp. phenothiazines. Slow, rhythmical, automatic stereotyped movements, either generalized or in single muscle groups.

Evaluation and Assessment

1. List and describe 10 physiological changes and common health problems that are related to aging.
2. List 10 techniques a counselor might use to facilitate the therapeutic process with an older adult.
3. Explain why each of the techniques listed above in #2 would be used.
4. Compare possible differences in counseling a relatively healthy older adult and one who is severely impaired.
5. Describe how assessment data with older adults might be used by the counselor.
6. Evaluate the use of assessment instruments in counseling older adults in terms of your theoretical orientation in counseling.
7. Describe at least 3 counseling strategies that might be used with older adults based on changed physiological status due to aging.
8. List at least 10 referral sources with which a counselor should be familiar in dealing with the elderly. Explain their importance.
9. Explain why crisis intervention techniques may be beneficial in counseling the elderly.
10. Discuss how a counselor might help a client plan for possible elimination or reduction of future occurrence of simultaneous stress.

MODULE IV

PSYCHO-SOCIAL ASPECTS OF AGING: AN OVERVIEW

James M. Brine

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PSYCHO-SOCIAL ASPECTS OF AGING

Rationale and Objectives

Gerontological counselors must be informed about the emotional and social aspects of life in the later years. Graduate students in the helping services have typically been exposed to the available theoretical and research knowledge about childhood and adolescence, with little or no emphasis on the remainder of the life cycle. Knowledge of the experience of the elderly will enable the counselor to distinguish between age-related and deviant behavior and to plan appropriate counseling strategies.

The objectives of this module are as follows:

(1) To present information about psychosocial conceptualizations of life in the later years.

(2) To present information about research results that explain people's normal adaptational processes to the circumstances of old age.

(3) To present information about the way people do or do not modify their views of themselves as part of the aging experience.

(4) To present information about changing roles and relationships within and outside the family.

(5) To present information about the attitudes of people in general and attitudes of family members toward the elderly and how these affect the elderlys' views of themselves.

(6) To present information about sexuality as a part of the aging experience.

(7) To present a discussion of age-appropriate behavior, age norms, and age roles and successful and unsuccessful aging patterns.

(8) To present a discussion of the effects of age-related changes on personality and about the interactions of maturing older persons within the changing social context.

Content

PSYCHOSOCIAL ASPECTS OF AGING

The older person progresses through some combination of psychological and social stages in his/her journey through the last period of life. In general, theories of personality and counseling guide counselors in their understanding of humankind and in making counseling interventions. Although each theory can aid the understanding of the practitioner, no one theory has yet been developed that explains all the vagaries of human nature or that can guide the counselor in dealing with all counseling needs.

Five conceptualizations of the experience of old age are briefly summarized in this section. They give the counselor information to help understand his/her clients and to formulate counseling procedures.

Jung (1933) recognized the importance of middle age and senescence as two of the stages of life. He pointed out that the assumptions, goals, and ideals that serve a person through the earlier stages of life do not provide the framework for a meaningful existence in middle and old age. He lamented that people are not prepared for old age by either formal or informal education. He also noted that old age is a period for introspection.

Erikson (1950) formulated eight stages of ego development encompassing the process of life from birth through old age. He presented each stage as a developmental conflict or crisis, with the successful resolution of each conflict leading to a positive adaptation to one's self, to one's inner demands, and to the demands of the external environment. His stages of life have been widely quoted and are generally considered cornerstones of explications of life-span development.

His final developmental conflict, ego integrity versus despair, provides a general psychosocial explanation of old age. The term "integrity" as used by Erikson is not meant to connote trustworthiness but rather an acceptance of one's life as having been meaningful (Erikson 1950). During this period of life, according to Erikson, people sense a gap between their accomplishments and their goals. To accept one's life as it has been lived can be a difficult task.

Some older persons become depressed when thinking about their past and resign themselves to an unhappy future. Others respond by becoming rigidly self-confident. To protect their self-esteem they reject self-doubt and present a picture of total confidence. Either strategy prevents possibilities for change and growth during old age.

An alternative response to this task would be for the older person to accept past disappointments and put them in perspective with his/her personal achievements. Having the flexibility to incorporate satisfactions and disappointments into a life history that on balance provides a source of self-pride and self-satisfaction enables one to find new directions for growth.

Peck (1968) found Erikson's final stage too global and nonspecific to account for all the psychological learning and adjustments that occur during old age. His conceptualization is described in terms of the following three conflicts:

1. Ego differentiation vs. work-role preoccupation: Redefining one's worth and finding satisfaction in aspects of one's selfhood and in new roles occurs at this stage for men and women who have had full-time vocational roles that contributed meaning and focus to their lives. When vocational retirement occurs, usually in the early sixties, a strenuous adjustment is required while the person finds new and satisfactory roles and finds satisfaction in aspects of his/her own selfhood that had been ignored. Making a successful psychological adjustment might spell the difference between a continuing vital interest in living and a despairing sense of loss of meaning in life.

2. Body transcendence vs. body preoccupation: The elderly are less resistant to illnesses, slower to recuperate from them, and more subject to feeling bodily aches and pains than they were in earlier years. For those for whom physical well-being is the cornerstone of comfort and pleasure, these bodily changes may bring about a drop in satisfaction and a growing preoccupation with the condition of their bodies. For those who have managed to find more happiness and contentment in satisfying human relationships and mentally creative activities, even physical discomfort should not prevent them from enjoying life. In the value system of those who have transcended an inordinate concern with their physical well-being, more importance is given to mental and social sources of self-respect and pleasure than to physical sources.

3. Ego transcendence vs. ego preoccupation: The certainty of death is a crucial fact of old age. Based on the suggestions of Eastern and Western philosophers, Peck (1968) has suggested positive ways for persons to adapt to the prospect of death:

> To live so generously and unselfishly that the prospect of personal death — the night of the ego, it might be called — looks and feels less important than the secure knowledge that one has built for a broader, longer future than any one ego ever could encompass. Through children, through contributions to the culture, through friendships — these are ways in which human beings can achieve enduring significance for their actions which goes beyond the limit of their own skins and their own lives. It may, indeed, be the only knowable kind of self-perpetuation after death. (Peck 1968, p. 91)

To adapt in this way requires an active and deep effort to make life more secure and meaningful for those who live on after one dies and to have a constructive impact on them.

Ahammer (1973) borrowed principles from learning theory in an effort to analyze life events and subsequent behavior into stimulus-response functions and then to examine the process of adult behavior change as a response to these life events. She focuses on the interaction of the older person with the environment. Her approach recognizes that developmental changes in late adulthood and old age are tied to landmark events (widowhood, retirement) and are directly connected with generalized biological maturation steps or with chronological age.

Sources of behavior change come from the external environment and not from internal organic changes. The individual's behavioral response to such landmark events as grandparenthood, widowhood, retirement, and moving to a different neighborhood can determine wholesome development. The counselor can become a teaching agent with the objective of helping people to respond more appropriately to such landmark events (external stimuli).

Havighurst (1959) enumerated a list of "developmental needs" that are faced by people from 60 to 75. The problems are "as complex as any problems faced during a lifetime. In fact, later maturity requires more learning of most people than they have had to achieve since their early adulthood. Later maturity is, then, a period of learning, rather than a period when learning is past. It is a period of facing new and unsolved problems, rather than a period of floating gently on the surface of familiar solutions to familiar problems." (Havighurst 1959, pp. 441-442). Some of the following developmental tasks or learning problems are challenges to be solved by any person who lives through older adulthood:

Adjusting to the death of a spouse
Adjusting to loss of employment and reduced income
Affiliating with the age group of elders
Adjusting to a decline in physical vigor
Adjusting to changes in living arrangements
Developing new social roles that bring recognition and respect
Using leisure time in satisfying ways.

SUCCESSFUL AND UNSUCCESSFUL AGING

In a training manual for counselors of older persons it is important to talk about "successful" and "unsuccessful" aging. There are many productive and unproductive strategies by which people arrange and carry on their lives after middle age. Research has provided much information about these strategies. Very old age is often accompanied by serious illnesses and accumulated losses that interfere with the ability to remain independent. Successful old age in such conditions may mean dying with dignity. (The reader is referred to Module V-C for more extensive coverage of the dying client.) The attention here is focused on individuals who do not yet have terminal illness and their adaptations – successful and unsuccessful – to aging.

The concept of successful aging implies a value judgment that says that some adjustments are better than others. People accommodate themselves to old age in various ways – no standard or best route of adjustment can be put forth.

> The socially accepted criteria of adequate adjustment in old age include the following: congruency between inner mental states and external circumstances; a degree of continuity between past and present patterns of adjustment; acceptance of old age and death; a degree of euphoria arising out of security and relief from responsibilities; and, most important, security and adequate financial circumstances. (Bromley 1974, p. 266).

Disengagement Theory

The earliest theory of successful aging, the disengagement theory (Cumming & Henry 1961), attracted a great deal of attention from students of gerontology and has been highly controversial. This theory describes the process of aging as one in which there is decreased interaction between the aging individual and society. It is a mutual withdrawal by society and the older person; the aging individual wants the decreased interaction. Withdrawal is a developmental process. Along with the withdrawal and the decreased social interaction, there is an increase in preoccupation with the self and a lessening of emotional investment in others and in the affairs of the world.

Thus, disengagement is not imposed but is a natural process and the older person who has a feeling of psychological well-being will be one who has reached a new balance characterized by decreased social interaction and a greater psychological distance from those around him/her. Successful aging, according to this theory, means coping with disengagement successfully. A person who maintains a high level of activity and involvement during old age would be considered to be aging unsuccessfully.

Activity Theory

The activity theory holds that the values and activity patterns typical of middle age must be maintained into old age in order for a person to age successfully. This implies that older people have the same psychological and social needs as middle-aged people. In this view, any decreased social interaction results from society's withdrawal from the older person. The resulting decrease in social interaction proceeds against the wishes of most older people.

The person who ages best, according to activity theory, stays active and finds substitute activities for work when forced to retire. S/he also finds substitute partners and friends for those lost by death. Thus, successful aging occurs as long as one maintains a level of activity and social interaction characteristic of middle age.

If an aging individual were to conform to either of these patterns of aging, s/he would be considered to be aging successfully by the proponents of that theory. But not only are the two theories contradictory, they also fail to provide all the answers for a recipe for successful aging. Since it is a fact that some older people are satisfied with a high degree of social interaction while others are satisfied with a small amount, more information is needed to provide a useful theory of successful aging.

Social Reconstruction Approach

Of special interest to counselors is the social reconstruction model (Bengtson 1973), which borrows from theories and traditions in community psychiatry and sociology and applies them to practical problems of adjustment in aging. It is assumed that social-environmental conditions directly affect mental health and that *an individual's self-concept depends on* a combination of the way the person performs in everyday social interactions and the way others react to him/her.

Zusman (1966) has demonstrated in his "social breakdown syndrome" the way in which one's self-concept can interact with one's social environment "to produce a vicious spiral of negative psychological functioning" (Bengtson 1973, p. 47). Although this conceptualization was designed to explain society's contribution to creating "mentally ill" persons, it also applies to the societal interaction that the elderly person encounters.

The Social Breakdown orientation suggests that an individual's sense of self, his ability to mediate between self and society, and his orientation to competence are related to the kinds of social labeling and valuing he experiences in aging. (Bengtson 1973, p. 47). Loss of familiar roles with no replacement for them, lack of reference groups, and inappropriate normative information,

> All serve to deprive the individual of feedback concerning who he is, what roles and behaviors he can perform, and what value he is to his social world. Second, this feedback vacuum creates a vulnerability to, and dependence on, external sources of self-labeling, many of which communicate a stereotypic portrayal of the elderly as useless and obsolete — a characterization common in a society which places so much importance on productivity. Third, the individual who accepts such negative labeling is then inducted into the negative, dependent position — learning to act like old people are supposed to act — and previous skills of independence atrophy. Fourth, he accepts the external labeling and identifies himself as inadequate, setting the stage for another vicious spiral. Thus, the Social Breakdown Syndrome characterizes the dynamic relationship between susceptibility, negative labeling, and the development of psychological weakness. We have suggested it applies to many elderly individuals in American Society. (Bengtson 1973, pp. 47-48)

In order to break the vicious cycle of social breakdown, Kuypers and Bengtson (1973) suggested structuring inputs at many levels. The work of counselors, other helping professionals, and planners toward meeting the needs of the elderly are attempts to make beneficial inputs to break the cycle. Bengston (1973) suggested

> that the process be viewed as a "Social Reconstruction Syndrome." This model (see Figure 1) does two things: (1) it characterizes the dynamic interaction between the individual and his social system as he moves through time, and (2) it portrays some inputs which can be made to assist the elderly.
>
> Entries outside the circle (i.e., external inputs to the system) are conditions of the environment and activities of practitioners which aid the establishment of the Social Reconstruction Syndrome. The aged are vulnerable in our society — the latter stages of the life cycle imply many potential problems. Three major types of inputs to ameliorate these problems were suggested. First, efforts can be made to liberate the individual from an age-inappropriate view of status: the functional ethic, which suggests self-worth is contingent on performance in economic or "productive" social positions, is particularly inappropriate in old age. In counseling, for example, one might urge the older person to adopt a more "humanitarian" frame of self-judgment. A second type of input to the system affecting elderly individuals is improving social services to them or, to put it differently, enhancing adaptive capacity by lessening the debilitating environmental conditions faced by most older people, such as poor housing, poor health, and poverty. This would facilitate coping skills. Third, we suggested that, to enable the development of an internal locus of control, those who envision themselves as serving the elderly must divest some of their own power and control: self-determination by the elderly and individual control of policy and administration is the foundation for competent aging. (Bengtson 1973, pp. 48-49).

Input toward reconstruction can be made by counselors and others interested in helping the aging individual. Input can also be made by other social service agency personnel and by legislators concerned with the welfare of the aging population. In this way a benign circle will be created to effect a reversal of the social breakdown syndrome.

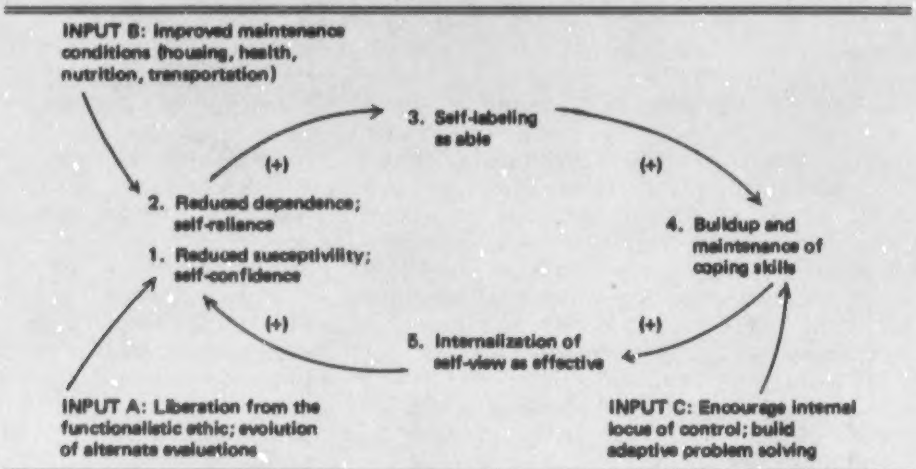
Personality and Successful Aging

Two important research studies have provided material that incorporates the dimension of personality into a review of the conditions necessary for successful aging.

The Kansas City Study of Adult Life by Neugarten, Havighurst, and Tobin (1968) extracted per-

FIGURE 1

The Social Reconstruction Syndrome


INPUT B: Improved maintenance conditions (housing, health, nutrition, transportation)
3. Self-labeling as able
(+)
(+)
2. Reduced dependence; self-reliance
1. Reduced susceptivility; self-confidence
4. Buildup and maintenance of coping skills
(+)
(+)
5. Internalization of self-view as effective
INPUT A: Liberation from the functionalistic ethic; evolution of alternate evaluations
INPUT C: Encourage internal locus of control; build adaptive problem solving

From *The Social Psychology of Aging*, by Bengtson, V. L., copyright © 1973 by Bobbs-Merrill, Inc., reprinted by permission.

sonality types from the data. The results of the study in some ways support the activity theory; high activity was correlated with high affect and low activity with low affect. Other results of the study support the disengagement theory; some older persons still involved in much activity would have liked to withdraw from many of their obligations while others enjoyed relatively inactive lives.

To learn about the effects of the personality dimension on successful aging Neugarten, Havighurst, and Tobin isolated the 59 men and women between the ages of 70 and 79 and applied a statistical analysis to their data. Fifty of these people clearly exhibited one of the following eight patterns of aging. They (1968) described these eight personality types as follows:

> Group A, called the reorganizers, are competent people engaged in a wide variety of activity. They are the optimal agers in terms of the American ideal of "keeping active, staying young." They reorganize their lives to substitute new activities for lost ones.
>
> Group B are called the focused. They are well-integrated personalities with medium levels of activity. They tend to be selective about their activities, devoting their time and energy to gaining satisfaction in one or two role areas.
>
> Group C are called the successfully disengaged. They have low activity levels with high life satisfaction. They have voluntarily moved away from role commitments as they have grown older. They have high feelings of self-regard, with a contented "rocking-chair" position in life.
>
> Group D exhibits the holding-on pattern. They hold as long as possible to the activities of middle age. As long as they are successful in this, they have high life satisfaction.
>
> Group E are constricted. They have reduced their role activity presumably as a defense against aging. They constrict their social interactions and maintain a medium to high level of satisfaction. They differ from the focused group in having less integrated personalities.
>
> Group F are succorance-seeking. They are successful in getting emotional support from others and thus maintain a medium level of role activity and of life satisfaction.
>
> Group G are apathetic. They have low role activity combined with medium or low life satisfaction. Presumably, they are people who have never given much to life and never expected much.
>
> Group H are disorganized. They have deteriorated thought processes and poor control over their emotions. They barely maintain themselves in the community and have low or, at the most, medium life satisfaction. (pp. 196-198)

The first four types measure high in life satisfaction. The next two (constricted, succorance-seeking) measure high or medium and the last two (apathetic, disorganized) are considered medium or low in life satisfaction. Although there are no longitudinal studies to prove the point, Neugarten, Havighurst and Tobin (1968) think that these personality patterns are established and predictable by middle age.

Eighty-seven elderly working men were rated on adjustment to aging by Reichard, Livson, and Petersen (1962). From this group they identified men who were similar to one another in personality. Two thirds of the men had personality characteristics similar to enough other men that five personality types, having five different strategies of adjustment to old age, were identified.

The three types high in adjustment were given the following names: mature (N=14), rocking-chair (N=6), and armored (N=7). The mature men were constructive in their approach to life. They tended to be intelligent, optimistic, self-sufficient, and neither neurotic nor anxious. The rocking-chair types tended to be dependent and passive rather than active and self-sufficient. They were basically well-integrated but unambitious individuals. The armored group were defensive; they seemed to fear the relative inactivity and dependency of old age, putting off retirement and maintaining a busy schedule to prevent themselves from confronting the facts of old age. They tended to be compulsively active, conventional, emotionally overcontrolled, and habit-bound.

The two types low in adjustment were given the following names: angry (N=16) and self-haters (N=4). The angry group were aggressive and complaining as well as competitive and suspicious. They tended to blame other people or the world in general when things went wrong. Their views were simplistic and they were prejudiced against minority groups. Many had had an unstable occupational life and had been downwardly mobile. With little to reflect on favorably about the past, they saw nothing good about old age and were afraid of death.

The self-haters differed primarily from the angry men in that they had turned their hostility in on themselves and were depressed. They were passive, unambitious, irresponsible, and had been occupationally unsuccessful and downwardly mobile. They were little interested in other people. Their main feelings were regret, depression, and self-recrimination. They were not worried about death because they saw it as a release from an intolerable existence.

OLD AGE, SELF-CONCEPT, AND SELF-ESTEEM IN THIS CULTURE

In Eriksonian theory the final developmental conflict is ego integrity versus despair. The achievement of integrity can only come after much reflection about the meaning of one's experience of life. As he uses the term "integrity" Erikson means the ability to accept one's life and to face death without undue fear. Integrity is an ability to integrate present circumstances with past history and to feel reasonably content with the outcome. Older people who have achieved integrity appreciate the fact that their lives are the sum total of their satisfactory experiences and unpleasant crises. The integrity-achiever can accept this record of events completely without trying to make too much of some facts or to deny others. The ways in which one achieves ego integrity are tied in with one's self-concept and self-esteem.

Humans are the only animals with the ability to think about themselves. They can think about their behavior, their bodies, their appearance to others, and their minds because of their ability to use language and to think abstractly. Humans define themselves by the way they interpret perceived feedback from within themselves and from others. Through a variety of interactions humans gradually differentiate their knowledge of self from their total knowledge.

The self is organized but flexible. People attempt to integrate all their life experiences and thoughts into their self-concept system. The self, therefore, is an intrapsychic system that feeds itself and also receives feedback from others.

The cognitive element of the self is called the self-concept, one's description of one's self. The emotional element of the self is called self-esteem, or how one feels about self-concept in comparison with an ideal — whether a person is proud of it, ashamed of it, likes it, dislikes it.

One would think that in old age self-concept and self-esteem would be ravaged by a society that overvalues youth and remunerates productivity and economic power, attributes that the elderly do not have. In addition, the role changes required by retirement, widowhood, sickness, and disability require enormous adjustments. Nonetheless, for a number of reasons moving through old age does not bring about drastic changes in self-concept and self-esteem.

Neugarten (1965) found that certain personality characteristics are subject to change in later life while others remain consistent over time. Those dimensions of personality that are relatively covert tend to change while those that are overt tend to remain stable. The intrapsychic qualities of personality — qualities about which data were obtained through the use of projective techniques — differed for individuals of advanced age when compared to those for individuals in middle age: "Different modes of dealing with impulse life became salient with increasing age. Preoccupation with the inner life seemed to become greater .... There was a movement from outer-world to inner-world orientations" (Neugarten 1965, p. 11).

The socioadaptational qualities of personality, those which are relatively overt, purposive, and subject to conscious control, showed relatively little change over time:

> Thus where the focus was upon such generalized variables as Erikson's "generativity" or "integrity," or upon personal-social "adjustment," or upon "differentiated social perceptions," or "super-ego control," no age differences were found. (Neugarten 1965, p. 12)

Thus, the most striking personality change from middle to later life is that of increased inner orientation.

The majority of adults over 60 perceive themselves as "middle-aged," not "elderly." This resistance to seeing oneself as elderly suggests that active, healthy, involved older people may wish to make a distinction between themselves and older adults who are ill, irritable, and passive. Mason (1954) has also shown that older people who live independently have more positive self-attitudes than those who are institutionalized. One strategy older people tend to use to defend themselves against negative self-attitudes is to identify themselves as younger.

SOCIAL ASPECTS OF AGING

Role Changes in Old Age

Although Erikson (1950) and Peck (1968) emphasized the intrapsychic nature of the process of growing old, the interactional nature of aging in this society (i.e., the effects of major life events on the developmental processes of the aging individual) has been noted by Ahammer (1973). The activity and disengagement theorists have pointed to the effects that greater or lesser involvement with people, groups, and issues in society at large have on the aging individual. The roles older people discontinue, those they espouse, and others' attitudes toward them affect their world view, the way they define themselves, the way they feel, and their place in society.

The social role of senior citizen is less clearly defined than the roles assigned to young and middle-aged adults. The term "social role" implies the context of a specific behavior pattern or a particular situation. Since individuals often define themselves in terms of social roles and the roles determine the individual's place in society, social roles are significant. As people pass through the stages of life, the variety of positions for which they are eligible keeps changing. Available roles are more ambiguous in later life and often require major adjustments. Many roles have negative connotations. The roles available to the elderly may involve those associated with retirement, widowhood, dependency, disability, sickness, and institutionalization.

"Ill," "tired," "uninterested in sex," "mentally slower," "forgetful," "less able to learn new things," "grouchy," "withdrawn," "self-pitying," "less likely to participate in activities," and "unproductive" are some of the stereotypical terms commonly applied to the elderly.

Attitudes Toward the Elderly

The results of an extensive poll on attitudes toward the elderly were published in The Myth and Reality of Aging in America (Harris 1975). Men and women of all ages participated in the study. The data on the Black elderly were analyzed separately as well as in the total sample. The attitude of the general public toward old age is a distortion of what old people report about themselves.

Many older people have accepted the myths and stereotypes of old age. Those who consider their own circumstances to be all right look upon themselves as exceptions to the rule. They perceive themselves as "bright," "open-minded," "alert," "adaptable," "useful member of the community." Both older whites and older Blacks see themselves as being wise from experience, friendly and warm, and sexually active. Older whites have a better self-image than older Blacks. Blacks 65 and over have stronger feelings than older whites that they do not receive sufficient respect from the young (Harris 1975).

Family Relationsips

In the postretirement years the entire nature of one's family role changes. The parental role includes providing children with emotional, social, and financial support. After children mature, leave home, and establish their own lives, a role reversal often occurs in which the middle-aged children provide various kinds of support for their aging parents.

In spite of the widespread modern notion that the advent of the nuclear family has destroyed the extended family network in the United States, survey results indicate the existence of a modified extended family, with complicated networks of interaction, service, and aid. The current status of the grandparenthood role is under study. Recently grandparenthood has become a phenomenon of middle age rather than old age and the four-generation family has become common. Three significant styles of grandparenting have been described: the formal grandparent, the fun-seeker, and the distant grandparent.

The primary couple relationship (usually marital) is probably the most important relationship in the adult years. Older couples are less likely to report marital problems than younger couples.

Single, Widowed, and Gay Elders

Single elders represent a proportion of about 8 percent of the over-65 population and are in some ways the group most prepared to adapt to old age. Since they have not been married and have led a life of relative isolation, they are not subject to the desolation that afflicts those confronted with the death of a spouse. Their daily life has followed a pattern of relative isolation. As Clark and Anderson (1967) state:

> Many old bachelors like Mr. Ebenhauser, who have maintained a social distance from others throughout their lives, often appear to function well, as though they have had a lifetime of practice in the self-reliance and autonomy required of many old people. Since they have never been close to others, they are spared the grief and loneliness of those who, having invested in and been intimate with others, must suffer the loss of a cherished relative, spouse, or friend. (p. 257)

Widowed older persons are subject to desolation when their long-term primary relationship is disrupted by the death of their partner. Counselors who begin to work with the aged are often overwhelmed by the apparent loneliness of older people. As the result of the death of a spouse or other close person, many older people have no one with whom they can share a close relationship. They suffer emotional deprivation, being left alone by the one person they would have most wanted to be with. Because the emotional investment was strong and deeply ingrained, the loss is severe. For most older people, there is little likelihood of forming a satisfactory substitute relationship. The kind of psychological stress that follows bereavement is associated with poor physical and mental health and with a higher incidence of death.

Older gays also demonstrate patterns of long-term partnerships (Kelly 1977). They suffer societal discrimination as gays in addition to the usual problems of age stigmatization encountered by straight older Americans. Inheritance (legality of wills), property ownership, and hospital visiting regulations (immediate family only) are some of the discriminatory situations faced by an aging gay partnership. Gay female relationships are usually stable and long-term; female partnerships would be analagous to a long-term straight marriage or to a series of medium-length relationships. The majority of older gay men are sexually interested in and content with relationships with adult men, frequently men in their own age group. The number of gay men involved in partnership liaisons increases with age; six out of ten gays in the 46 to 55 age group are involved in a partnership, but partnerships then decrease to almost none due to death or "divorce." Bereavement is a salient factor in the experience of aging gay persons.

Sexuality

The what, how, where, and with whom of sexual needs is as much a part of human existence in senescence as it was during adolescence and middle age. Research in human sexual behavior beginning with the first Kinsey report (Kinsey, Pomeroy & Martin 1948) and continuing through the well-known work of Masters and Johnson (1966), has helped to make inroads in ending the Victorian myth that sexual needs decrease in old age.

> Aging induces some changes in human sexual performance. These are chiefly in the male, where orgasm becomes less frequent and where more direct physical stimulation is required to produce erection, but compared with age changes in other body systems, such as muscular strength or vital capacity, these changes are functionally minimal. In fact, in the absence of disease, sexual capacity is life-long, and even if and when actual intercourse fails through infirmity, the need for other aspects of the sexual relationship such as closeness, sensuality, and being valued persists. (Comfort 1976, p. 1)

Sexual dysfunctions, which have been well documented by Masters and Johnson (1966), can occur at any point in the life span including old age. The most commonly cited dysfunction of the elderly male is inability to achieve erection and that of the elderly female is lack of vaginal lubrication. External lubricants can alleviate the female dysfunction but the male inability to achieve erection has been treated in many different ways, with a mixture of success and failure.

Finkle and Finkle (1977) are two urologists who have studied various methods of treating elderly male impotence and have concluded that most sexual problems of older men are psychogenic rather than organic. Recent lowering of self-esteem is a frequent cause of impotence. In these cases, Finkle and Finkle found that three sessions of supportive counseling to reestablish self-esteem were the most advantageous form of treatment to restore the ability to achieve erection.

The large proportion of elderly people who have no sex partner remains to be considered. Studies have shown that many of these people continue to have sexual urges. Rubin (1976) reports,

> that many older persons engage in the practice of masturbation, when a partner is unavailable. Because of the traditional emphasis upon this practice as not only a sin, but a childish form of behavior that becomes abnormal when engaged in beyond adolescence, many older persons are disturbed by their need to masturbate and require the assurance of counselors to accept it as valid practice. (p. 28)

Implications for the Counselor

To understand a client population of older persons the counselor must know the theories of human aging and the various ways that people with different personality types cope with aging. Also important for the counselor to know are the feelings, attitudes, role changes, and relationships that are likely to be experienced by older persons.

The counselor needs to understand the following:

1. The older client has an increased pressure to adjust to an environment where change and loss assail a person at a sometimes overwhelming rate.
2. The people and institutions around the older client step back a bit, creating distance.
3. Newly widowed or divorced older people living alone suffer more trauma than those who have been self-reliant for a long time.
4. Short-term supportive counseling can help in many cases of elderly male sexual dysfunction. The counselor can help assuage the guilt of the client who engages in masturbation. Knowledge of sexuality in older adulthood is a must for counselors. The counselor, of course, must come to terms with his/her own feelings of sexuality before s/he can deal effectively with older clients' sexuality.
5. Depression is a frequent companion to old age. It is characterized by an intense feeling of sadness resulting from a loss of personal power. The gerontological counselor should focus on aspects of client experience where personal power can be exercised.

Elderly clients experience multiple losses. One of the effects of such losses is the client's predisposition to become more dependent (or less independent). Young and middle-age adult counselors are, like all people, dependent on others for emotional support and caring, yet they retain an area of independence in their lives. For the older client there is a real need for added dependence in some areas of life. Gerontological counselors have a responsibility to critically examine their own encouragement of dependence, stemming from their need to be nurturant. The gerontological counselor must be aware of the possible paradox of encouraging independence while allowing increased dependence.

The following implications for counselors are based on the theories described in the content section:

1. In the absence of despair the counselor should place a high priority on helping the elderly client to review his/her life history. It is assumed here that, after people review past accomplishments, unfinished business, and disappointments, and have accepted all of these, they can face the end of life with integrity (based on Erikson).
2. At the time of the first role changes in old age (e.g., vocational retirement) the gerontological counselor might place a priority on helping the client gain an awareness of hitherto untapped aptitudes and interests and offer supportive counseling while the client adjusts to new roles (based on Peck).
3. In working with elderly clients a counselor should help them look for sources of satisfaction and contentment in human relationships and in mentally creative activities rather than in physical comfort or in physical pride based on society's definition of physical beauty (based on Peck).
4. Counselors should encourage older clients to make an effort to provide for those around them in a way that would reduce stress and give support to those who live on after they die (based on Peck).
5. Counseling older people calls for a teaching relationship in which the counselor assists the older client in accomplishing developmental tasks or responding to challenging new stimuli from the environment of late life experience (based on Ahammer).
6. The gerontological counselor ought to encourage the older client to continue to engage in a variety of meaningful activities to maximize emotional well-being (based on activity theory).
7. One of the important objectives of gerontological counseling is to support one's client in creating distance from many of those life activities that absorbed time and energy during the middle years and to be supportive during the inevitable creation of distance from the client by others (based on disengagement theory).

SOCIAL DISENGAGEMENT

Goal: To experience a simulation of social disengagement.

Group Size: An unlimited number of groups of approximately six participants each.

Time Required: One-half to one hour.

Materials: None. (It is assumed that reading on disengagement has been accomplished.)

Physical Setting: A room large enough to allow small groups to work without distracting one another. Moveable chairs.

Process:

1. The instructor introduces the experience as a nonverbal activity with the aim of getting in touch with the feelings of (a) a retiring 70-year-old disengaging herself/himself from society and retiring from work, and (b) individuals in the social network disengaging themselves from the 70-year-old.
2. Groups of six persons each are formed; additional persons serve as observers.
3. The instructor assigns each group member a role as (a) the 70-year-old, (b) three of his/her close fellow workers, (c) his/her supervisor at work, and (d) a member of the car pool.
4. The instructor asks the group to stand shoulder-to-shoulder in a tight circle facing the center. The instructor asks the six group members to get in touch with the feelings of solidarity that existed during the height of the 70-year-old's working career. (nonverbal — take two minutes.)
5. The instructor announces that it is time for retirement. Ask the person playing the 70-year-old to move one step away from the group. While the other five remain close together (shoulder-to-shoulder), ask them to move in unison one step away from the 70-year-old. Experience feelings of disengagement from one another (60 seconds). Ask each side to take one more step. Get in touch with feelings (60 seconds).
6. Have a discussion in which all participants share the feelings they experienced during the disengagement process. Ask the observers to describe the body language of the participants.

ROLE CHANGES OF ELDERLY FAMILY MEMBERS

Goals:

1. To experience the structural changes in a nuclear family with an elderly member.
2. To learn the effects on all family members of the role changes of elderly family members.

Group Size: An unlimited number of groups of 6 to 15 participants each.

Time Required: Approximately one half-hour.

Materials: None. (It is assumed that previous reading on role changes has been accomplished.)

Physical Setting: A room large enough to allow small groups to work without distracting one another. Moveable chairs.

Process:

1. The instructor introduces the experience as a nonverbal activity with the aim of getting in touch with the family members' feelings during the role changes of elderly family members.
2. Groups of six persons each are formed; additional persons can serve as observers.
3. Instructor assigns roles of father, mother, grandfather, three teenage children to group members.
4. Father, mother, and three children stand holding hands in circle for three minutes. They are asked to get in touch with their feelings as members of this nuclear family group. They can exchange glances with one another if they wish but are asked to refrain from talking.
5. Grandfather stands outside circle looking at the other family members. Instructor tells group that a combination of circumstances, including grandfather's recent widowhood at the same time as a reduction in his annual income, requires grandfather to move into the home of one of his adult children.

6. At the end of three minutes instructor asks grandfather to enter the family group and to take his place in it. All participants are cautioned to continue to refrain from talking. This portion of the exercise takes three minutes.

7. During the next 24 minutes the participants are asked to share their experiences during the exercise with one another.

Variations:

1. Family of six with grandmother, parents, and teenage children stand in circle holding hands for three minutes. At end of first three minutes instructor announces that grandmother has become infirm and needs more care than the household can provide. She is to leave family group to enter extended care facility. Three minutes (minimum and maximum) are allowed for grandmother to leave. Repeat step 7 above.

2. Family composition variations: (a) single-parent family with elderly grandparent, (b) ascribe ethnic characteristics to family members, e.g., Hispanic-American, Black, WASP.

ADULT LIFE STAGES

Goals:

1. To enable participants to get in touch with their own process of passing through life stages.
2. To learn about the differences in the stages of adult life.

Group Size: Ten or more. See the process section for suggestions for using the fishbowl technique with larger groups. The ideal group size is 20 to 30 but the activity can be done effectively with larger groups as well.

Time Required: Fifteen minutes to two hours. Fifteen minutes for minilecture. (When working with a large group of 20 to 40 people, each age-stratified discussion will need 10 to 20 minutes.)

Materials: The background information for this exercise and the graphs depicted on the slides were taken from Gould, R., "Adult Life Stages: Growth Toward Self-Tolerance" (Psychology Today, February 1975, pp. 74-78). (See Appendix A.)

Slide projector. Eighteen color slides depicting the findings of "Adult Life Stages."

Physical Setting: A room large enough to allow small groups to work without distracting one another. Moveable chairs.

Process:

For entire group present background information about the "Adult Life Stages" article. Then show slide presentation of statements indicating different attitudes of each adult life stage. With Slide 1 explain the vertical and horizontal lines on the graph. Time should be allowed for group members to absorb the information and to ask questions about each graph. Time should be allowed for group members to speculate on the reasons for the dip in the thirties.

If the group is composed of 20 or more people, the fishbowl approach is recommended for small group discussions. Ask for a show of hands indicating the number of people in each age group, for example, 37 to 43, 44 to 50. (It is assumed that in a group preparing to counsel the aging, age denial will not be an issue. Continued denial gives a group member information about a personal area that needs work.)

Assemble each group one at a time in chairs in the center of the room with the remainder of the participants sitting in a larger circle outside. Instructor serves as a small group discussion leader with inner group. Instructor begins discussion by reading the general description of the age group the group members have most recently passed (from "Adult Life Stages"). Then the instructor moderates a discussion in which group participants are encouraged to share their own life experiences from the previous stage and to express the applicability (or the opposite) of the study's findings to their own life experience.

Example: Ask the 44-to-50-year-old age group to identify themselves by raising their hands and invite them to join you in the center of the room. Prepare chairs in the center of the room to accommodate the group leader and all group members age 44 to 50.

Tell group members the purpose of the small group is to have an opportunity to discuss the research results they have just seen, but only in terms of its applicability to their own life experience. Each of them is a special resource person about the life stage preceding the one they are going to discuss.

Read aloud the description of the preceding stage (from "Adult Life Stages"). In this instance it was as follows:

> The 40s seem to begin in the late 30s, and I distinguish a series of shared sentiments spanning the ages 37 to 43. In this age period, personal comfort decreases, and marital comfort remains at a low level. Between 40 and 43, there are several temporary departures from previous levels on statements dealing with personal comfort, suggesting that the 40s are an unstable and uncomfortable time. Later in the 40s both friends and loved ones become increasingly important. Children continue to be very important, and there is a sharp rise in regrets for "my mistakes in raising my children".
>
> Money, so bothersome because of its insufficiency in the early 30s, becomes less important, and there is an accompanying feeling that it is "Too late to make any major change in my career." Coupled to the first downward shift in the feeling that "There's still plenty of time to do most of the things I want to do," these responses show a 40s phase of reconciliation of what is with what might have been. (pp. 77-78)

To facilitate discussion, the instructor can comment that the description is highly generalized, based on a small sample, and assumes that marriage and child-rearing were a part of the previous adult life stage.

Members can handle this material as a general or as a personal issue. In a group in which the members are somewhat comfortable with the situation and with one another, people will tend to be very personal.

(Caution: Persons undergoing difficult life transitions will find this experience heavy going.)

EMPATHIZING WITH THE DAILY LIFE OF THE ELDERLY

Goals:

1. To develop empathy toward older persons and their day-to-day problems.
2. To develop awareness of some of the different styles of dealing with older persons.

Group Size: An unlimited number of groups of approximately seven persons each.

Time Required: For each structured role play and the subsequent processing 30 to 45 minutes should be allowed.

Materials: Twenty pairs of role descriptor cards for the structured role-play situations.

Physical Setting: A room large enough to allow small groups to work without distracting one another.

Process:

The instructor explains that the activity consists of a series of structured role-play situations. For each situation two volunteer group members will each be given a card describing his/her approach to the encounter between an elderly person and a significant other. The role descriptor cards identify the person involved in the encounter and briefly describe that person's world view. (In each case the attitude or understanding of the significant other is slightly different from that of the elderly individual. One or two minutes are allowed for the role players to read the descriptor card. Three minutes are allowed to role play the situation, followed by 25 to 40 minutes of processing.

Note: The role play situations lend themselves for use as counselor-training modules. Videotaping and playback are recommended as additional teaching tools for this purpose. (Role plays were developed in collaboration with Dr. Barbara DeFrank, Southern Connecticut State College.)

1. Older Person: You are an alert, active woman with many interests and friends at the senior citizen high-rise where you live. Your life is pleasant, with one exception. Your children frequently ask you to babysit and although you enjoy your grandchildren, you would prefer to be able to pick and choose your visits. You have signed up to go to the opera on February 10 and are looking forward to it with great anticipation. Saying no has always been difficult for you.

   Daughter: You are stopping at your mother's apartment in a senior citizen high-rise to ask her to babysit for you on February 10 because your husband has two tickets to a Broadway show which has been sold out for months. This will be your first night out in weeks because four children have had chicken pox.

2. Older Person: You are despondent and very depressed since your wife died three months ago. You have trouble eating and sleeping and you think life is not worth living without her. You are living in your home of 20 years and can't cope with any of your daily chores. Your neighbor has taken you to a counselor because he's worried about you.

   Counselor: You are a warm empathic person who enjoys success as a counselor at a senior citizen center. You have a deep regard for the dignity of personal choice and a delight for life and living.

3. Older Person: You are visited by the clergyman today. You think someone called him because you are dying. You feel very nervous wondering what his real reason is for visiting you. You are in a hospital room.

   Clergyman: You just drop by to say "hi" to those patients in the hospital who are members of your denomination. You walk into one of the rooms and this patient doesn't appear very happy to see you. You wonder why and what to do about it.

4. Older Person: You are a 68-year-old patient in the hospital. You have had tests taken and are awaiting the doctor's visit to tell you the results.

   Doctor: You are about to tell a 68-year-old patient that she will have to lose her left leg because of diabetes.

5. Older Person: You are a lonely widow(er) living alone in an apartment. You enjoy phone contact and call your friends regularly. You have just dialed your favorite phone friend.

   Peer: You are a senior citizen living in a senior citizen center. You have lots of friends and enjoy their company. Lately one of your friends has been calling you excessively. You are now having coffee with your friends and the phone rings. You plan on speaking your mind now.

6. Older Person: You have to pick out a wedding present for your granddaughter. She is very special to you and it is important that the gift be just right. You really don't know what you want but today is the only day you have to shop before the wedding. You stop at the crystal section because crystal seems to be appropriate, but you're not sure.

   Clerk: You work in the gift section of a department store. You are tired and eager to be relieved so you can meet your friend for lunch. You have something very important to discuss. Patience is not a virtue you possess to any great degree.

7. Older Person: You live with your husband in a private apartment in a nice section of town. You only go out for shopping, church, and appointments with your physician. There are two bright spots in your lives. One is the daily phone call from your only daughter. The other is the weekly outing either to her home where you can see your grandchildren or out to dinner and a movie with her and your son-in-law. It is comforting to have family nearby. You are joining your family now.

   Daughter: Your husband has just accepted a promotion and transfer 500 miles away. His new job means a considerable raise in pay. You are pleased with his success. You are an only child and are planning to tell your parents the good news tonight when they join you and your family for their weekly outing.

8. Older Person: You have just received your Social Security check and have come to the bank with your passbook, Christmas Club book and three bills to be paid by cashier's check. There is a new bankteller and you want her to get to know you so you'll have no trouble cashing checks.

   Bankteller: You work as a bankteller. It is 2:45 P.M. and the line is six people deep. It seems as if everyone has had complicated transactions today. You are sure you've made a mistake that will keep you here at least an hour after closing time. Your family is looking forward to an early dinner so they can all get on to weekend pleasures.

9. Older Person: You have been admitted to the nursing home after a prolonged illness in the local general hospital. You are sure that it is only a matter of weeks now before you will be on the road to recovery, once you have regained your strength. Your minister has come to visit you at the request of your family.

   Minister: You have been informed by the doctor that his patient (one of your parishioners) has about three weeks to live. She has inoperable cancer but does not know it. The doctor has asked you to visit the patient and offer her consolation. You feel that you cannot hide the truth of her condition from her, but at the same time you are very uptight because the doctor has not told the patient.

10. Older Person: You have adjusted well since your husband's death three years ago. You've sold your home and have been living comfortably in a senior citizen high-rise. You have an active social life and enjoy entertaining companions in your living room. You are pleased with your adjustment and feel good about yourself.

    Son: Your mother lives in a senior citizen high-rise apartment since your father died three years ago and their home was sold. You are concerned about her being alone and not well cared for. You feel it would be much better for her to be living with you and your family where she could be looked after and watched. Today you are meeting her for lunch when you'll tell her you insist she live with you in her own best interest.

11. Older Person: You are in a nursing home. Your family has given you some excuse about not inviting you to their home for Thanksgiving. You are very disappointed and resentful. You feel you must talk to them more about this and you do. You have a hard time understanding why you can't be with them. You feel they owe this to you and you are determined to get your way.

    Son: The Thanksgiving holiday is coming up. You want to enjoy this day with your wife and children. You don't look forward to having your father, who has had a stroke, with you. He is in a wheelchair, drools at the mouth when he eats, needs considerable help in eating, must wear a bib, and is generally a burden and unpleasant sight at the dinner table. You plan to visit him two days before Thanksgiving and must explain to him at that time why he can't come home with you to celebrate the holiday.

12. Older Person: You have been a patient at the facility for about three months and you still have not adjusted to schedules that demand you provide an aide with a urine specimen for an S and A test (sugar and albumin). You hate institutional living and feel that the staff completely disregards some of your needs in the name of efficiency. Today you are especially irritable since you did not rest well because of the noise from a roommate whose condition has worsened. The aide wakes you just when you are falling asleep. You decide to discuss this annoying situation with her. She wants another urine specimen from you just when you want to sleep.

    Aide: Before the end of your shift your duty is to take all of the urine samples for the S and A tests. You got a late start because one of the patients had a problem which required a lot of your attention. You are now very tired and eager to get done in record time so you can go home, but an elderly patient holds you up to talk to you. You try to get a urine sample from her as quickly as possible.

13. Older Person: You have decided today is the day you will take a risk to meet someone new in order to enlarge your circle of acquaintances. You're cheerful and friendly as you approach a foursome who are sitting down to lunch at a large table where there is one empty place.

    Peer: You have brought your lunch tray and sat down at the usual table with three of your four usual lunch companions. The fourth person will be 10 minutes late today. A person you have seen around for a few weeks but have not been interested in meeting approaches the table carrying a tray and wearing a broad smile.

14. Older Person: You are confused and upset. You can't seem to understand why your children (2 sons, 1 daughter) for whom you've slaved all your life don't call you every day or visit often enough. You're lonely and depressed since your husband died four years ago. You see your needs for attention as being a mother's just desserts. You've been having frequent headaches and your doctor suggested you talk to one of the counselors at the senior citizen center.

    Counselor: You are an independent, bright, assertive person. You were raised by two working parents who are in the teaching profession. You have little patience for people with dependency problems. You have been working at your first job, as a counselor in a senior citizen center, for three weeks.

15. Older Person: You are hesitant and shy. You have been seeing a gentleman friend who is five years younger than you are. You enjoy his company and feel the first real sexual excitement you've felt since your husband died two years ago. Your children are upset and have been telling you you're too old for romance, that you should become involved in church and volunteer activities, and not to be foolish. You wonder if something is wrong with your desires. It has taken a lot of courage for you to see a counselor at the senior citizen center.

    Counselor: You are a counselor working at the senior citizen center. You are in the midst of a divorce following the discovery of your mate's extramarital affairs. Your job is very important to you.

16. Older Person: You have just picked up your prescription at the drugstore and find that you question the price with your senior citizen discount. You wonder about the composition of the medication and about the possible side effects. You decide to question the pharmacist.

    Pharmacist: You are a pharmacist working in a neighborhood drugstore. The location is not your ideal. There is little excitement or challenge in your job and you are bored most of the time. You don't like to be questioned either. You feel you are right all the time and it is beneath you to have to explain yourself.

17. Older Person: From the time you were widowed five years ago, you have lived with your daughter and her family. You have your own comfortable room and even though your teenage grandchildren are a bit noisy, you enjoy being in a household with your family and expect to live out your life here.

    Daughter: Your father has been living with you since your mother died five years ago. You are a teacher but there were minimal inconveniences when he came; your sons were able to double up and give him their room. Now that they are teenagers they want more privacy. In addition, your father has shown beginning signs of senility. You are concerned about him. You fear your relationships with your husband and children will be increasingly affected by his presence and you fear you'll have to give up your career. You have decided to place him in a nursing home and today you have chosen to tell him.

18. Older Person: You are a healthy, retired man who has been unhappily married for 45 years. Your three children are established in lives of their own and you are financially independent. You are beginning to plan a divorce so that your remaining years can be spent in peace. You are meeting your eldest son for lunch and intend to tell him your plans. You would like his understanding.

    Son: You are meeting your father for lunch. You wonder why he asked to meet you. You are concerned with numerous business problems and are worried about financing your oldest daughter's college career. You give up the time reluctantly.

19. Older Person: You are a widow living with your son and daughter-in-law in a separate apartment in their home. It is a happy arrangement. The only thing that bothers you is a lack of friends. You left your hometown 300 miles away to come here to live and you sorely miss the companionship of your acquaintances. You have decided today to see a counselor at your church who helps senior citizens one afternoon a week.

    Counselor: You are a part-time counselor who works at various senior citizen organizations. Today is your day at a local church where you are available to deal with the concerns of senior citizens.

20. Older Person: You and your friend are going on your monthly theater trip by bus from the senior citizen center. Since she has become incontinent you find her repulsive to sit next to because her clothes smell of urine. You know your other friends are beginning to avoid her for the same reason. You meet your friend as you go into the office at the senior citizen center.

    Peer: You have been looking forward to your monthly theater trip. You enjoy sitting with your close friend and today is the day to make the bus reservation in the office. You meet your friend as you are going into the office and ask her to book your usual adjoining bus and theater seats.

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Simulation Games:

Brookside Manor, 1975, ($5.00). Dorothy Coons and Justine Bykowski. A leader's manual and instruction units compose the materials for a simulation dramatizing the needs of elderly people who leave their own homes for institutional life. Designed for 30 to play (it has been used effectively with groups of 16-60). 19-page leader's manual and 30 instruction sheets. Additional set of 30 instruction sheets for $1.50. Two hours playing time.

The End of the Line, 1975, ($3.50). Ansell Horn. This game simulates the interaction between providers of social services and older people in need of help and provides valuable insights into the helper-client relationship. (16-58 may play.) 54-page leader's manual. Two-and-one-half hours playing time. Both simulation games can be ordered from Gerontology Publications, Institute of Gerontology, 520 E. Liberty St., Ann Arbor, MI 48109.

Films:

Sex at Seventy. 29 minutes, 16 mm, sound and color. Rental fee $75.00, purchase price $395.00. Center for Marital & Sexual Studies, 5199 E. Pacific Coast Highway, Long Beach, CA 90804.

Trigger Films, 1971. Five brief films for discussion of issues in aging: income, health, loneliness, societal attitudes and responsibilities, intergenerational relationships, and life styles. 1-4 minutes each. Towsley Center for Continuing Medical Education, 271 E. Hospital Dr., Ann Arbor, MI 48109.

Evaluation and Assessment

1. Describe your own possible future adaptation to postretirement life according to (a) the activity theory, (b) the disengagement theory, and (c) the social reconstruction model.

2. Compare Erikson's concept of ego integrity versus despair with one of the following: (a) Peck's psychological conflicts, (b) Ahammer's social learning, or (c) Havighurst's developmental needs. Discuss the implications of the two concepts for counselors.

3. Describe how counselors, other helping services professionals, and planners can help reverse the social breakdown syndrome as it affects an elderly person. Be specific. (Note to instructor: Issue copies of a case study of your choice and request that answers be based on it.)

4. Cite and compare three of the social roles typically associated with age 45 to three of those typically associated with age 70.

5. Discuss the discrepancy between society's attitudes toward sex and the elderly and the personal sexual needs of aging individuals. What effect does knowledge of the needs and the discrepancy in attitudes have on gerontological counseling procedures?

ADULT LIFE STAGES

Growth Toward Self-Tolerance

Adults aren't fully forged by adolescence. Growth continues, from the confidence and optimism of the 20s through the doubts of the early 30s, the urgencies of the early 40s, and the mellowing and self-acceptance of the 50s. A probe of 524 men and women provides our first prospect for a comprehensive view of how adults grow up.

by Roger Gould

THE EVOLUTION OF A PERSONALITY continues through the fifth decade of life. A person does not possess the full range of his uniqueness after merely passing through adolescence, which is the last stage of mental development that many psychologists officially recognize. The process of formation continues through stages of life that we are just beginning to recognize. I began the research reported here to take a new look at the complex process of change in adulthood.

Although a 20-year-old may feel fully formed and mentally well-equipped to cope with life, that same person at 40 will ask how he managed to get through the last 20 years.

Many a man in his 40s wishes he had not been so blinded by his ambition in his 20s. His need to prove himself deprived him of irreplaceable experiences with his wife and children. "If I had only known then what I know now about what is important in living. It takes such a long time to find out what it is all about."

Many a woman in her 40s wonders why she was so foolish in her 20s. She lived up to the rules of householding and child rearing that were in vogue then, but sees them as unimportant now. "I was young then. I did what the doctor told me. I didn't pick the baby up when he was crying even though I knew I should. If only I had followed my own judgment."

Throughout the years of adulthood, there is an ever-increasing need to win permission from oneself to continue developing, through a process I will touch on later in this article. The direction of change is toward becoming more tolerant of oneself, and more appreciative of the complexity of both the surrounding world and of the mental milieu but there are many things that can block, slow down, or divert that process.

Each role in life can lead to two opposite results in the change process. A role can be an opportunity to come to a more comprehensive understanding of oneself in action or a role can become a simplified definition of the self that does not do justice to the whole complex human being. In that sense, a role that may be vitalizing at one period of life can become justifying at another.

We are many years away from having the experience and the studies necessary for an in-depth understanding of the adult period comparable to our current understanding of childhood and adolescence, and my formulations at this point are at best tentative. A number of other researchers are looking at various aspects of adult growth, and all of these studies are adding to our previously impoverished fund of knowledge about the subject.

Escape From Dominance. My colleagues and I began our search for adult life phases by observing and recording patients in group therapy at the UCLA psychiatric outpatient clinic. There were seven age-graded groups, with ranges of 16 to 18, 18 to 22, 22 to 28, 29 to 34, 35 to 43 and 50 and over. Our descriptions were not psychologically elegant. We sought a level of psychological description that would be intelligible to a layman. Most of the observations were both consistent among observers and congruent with common sense, which encouraged us.

We found, for example, that the youngest age group was at a period when escape from parental dominance was the predominant theme of their discussions. This concealed the feelings of dependence and anxiety that resulted from preparing to leave the sanctuary of the family. The future was both distant and unknown to these people. The next age group, those between 18 and 22 years, substituted friends for family, and thus continued to grow independent of their family.

The 22- to 28-year-olds definitely felt that they were the now generation. Now was the time to live, and now was the time to build for the future, both professionally and personally. These people concentrate their energies and will power on becoming competent in the real world, and as they develop self-reliance they make less use of their friends as a substitute for the family.

This assurance about what to do wavered somewhat among the 29- to 34-year-olds, who often were questioning what they were doing and why they were doing it. As they became more self-reflective, this group found deeper strivings that had been put aside during their 20s when building a workable life structure had been the most important task.

The continuing expansion of the personality and life structure continued in a leisurely fashion in the early 30s, but changed to quiet urgency in the 35-to-43 set. Time, once shrugged off as infinite, was now visibly finite and the view was often worrisome.

People between the ages of 43 and 50 had come to terms with time, and with themselves as stable personalities. What is done is done; the die is cast. Children previously cherished as extensions of oneself are now to be respected as individuals as they become young adults. The circle closes, as the adult raises a child who again becomes an adult.

Death: a New Presence. By 50, there is a mellowing of feelings and relationships. Children are a satisfaction, and parents are no longer the cause of one's personality problems. People of this age seemed to focus on what they have accomplished in half a century, and they were unrushed by the sense of urgency that accompanied the achieving 30s. At the same time, they were more eager to have "human" experiences, such as sharing the joys, sorrows, confusions and triumphs of everyday life rather than searching for the glamor, the glitter, the power or the abstract. Precious moments of contact and deep feeling define the value of being in touch. Death becomes a new presence for this age group.

With these general descriptions in mind, I devised a questionnaire to find the more exact periods during which people underwent a transition, and the nature of the things that concerned them the most. The original age categories were somewhat arbitrary, and the original subjects were those receiving psychiatric care. I wanted to see what age groupings would be distinguishable in the responses to the questionnaire, and whether the generalized sentiments found among the patients would be sustained by specific findings on a small sample of the nonpatient population.

I asked eight medical students to listen to tape recordings of the original patient discussions, and to list the statements about personal feelings that they felt stood out. I then grouped these statements into eight sections, covering relationships to parents, friends, children and spouses, and feelings about their own personality, job, time, and sexual behavior.

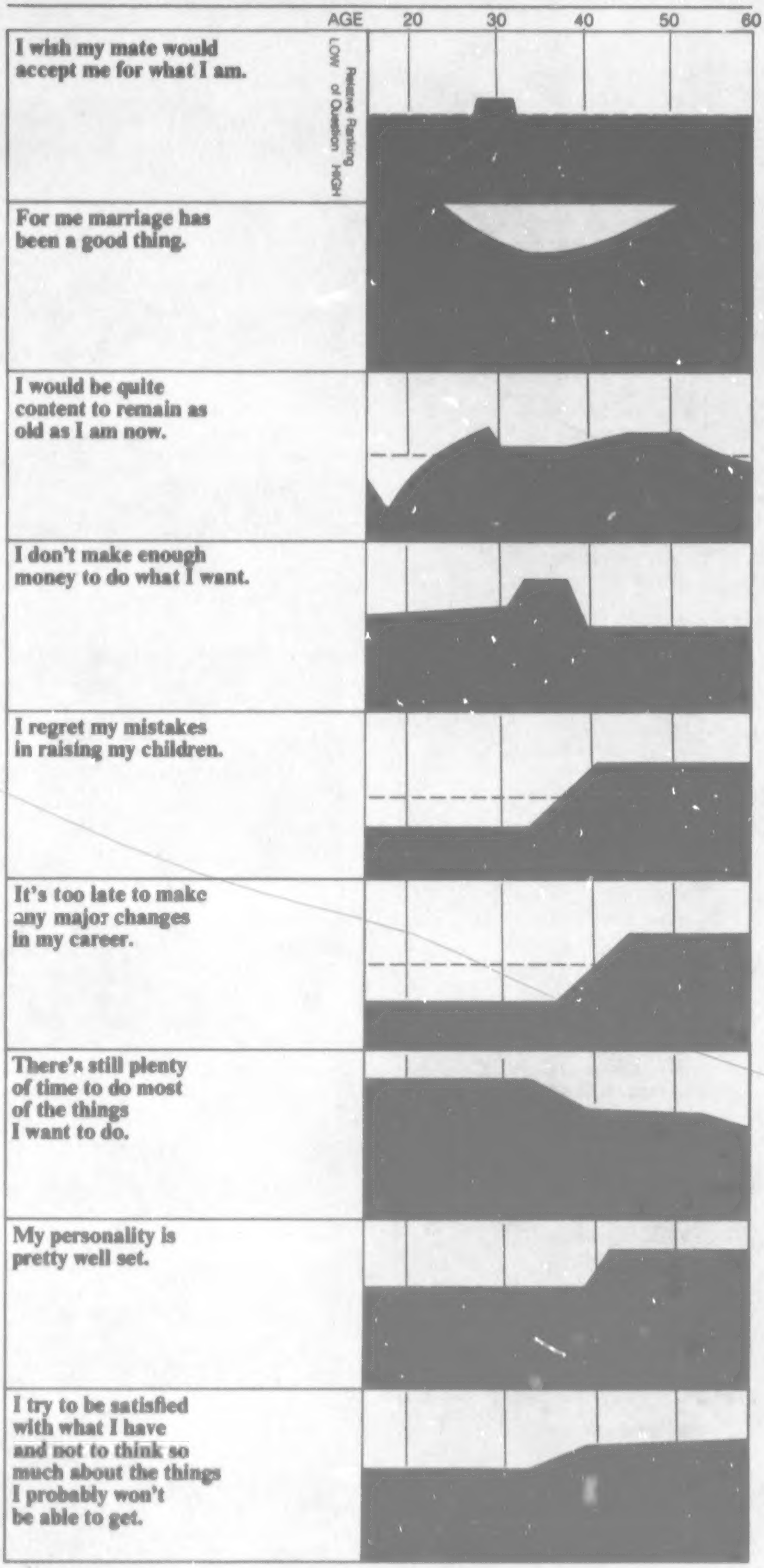
Each section had 16 questions. People ranked the questions from most to least applicable to their lives. There were no right or wrong answers, only changes in the importance of particular statements to people of various ages. Questions rose and fell in rank like the tide on a beach, providing a sensitive measure of the times of transition—and the tribulations.

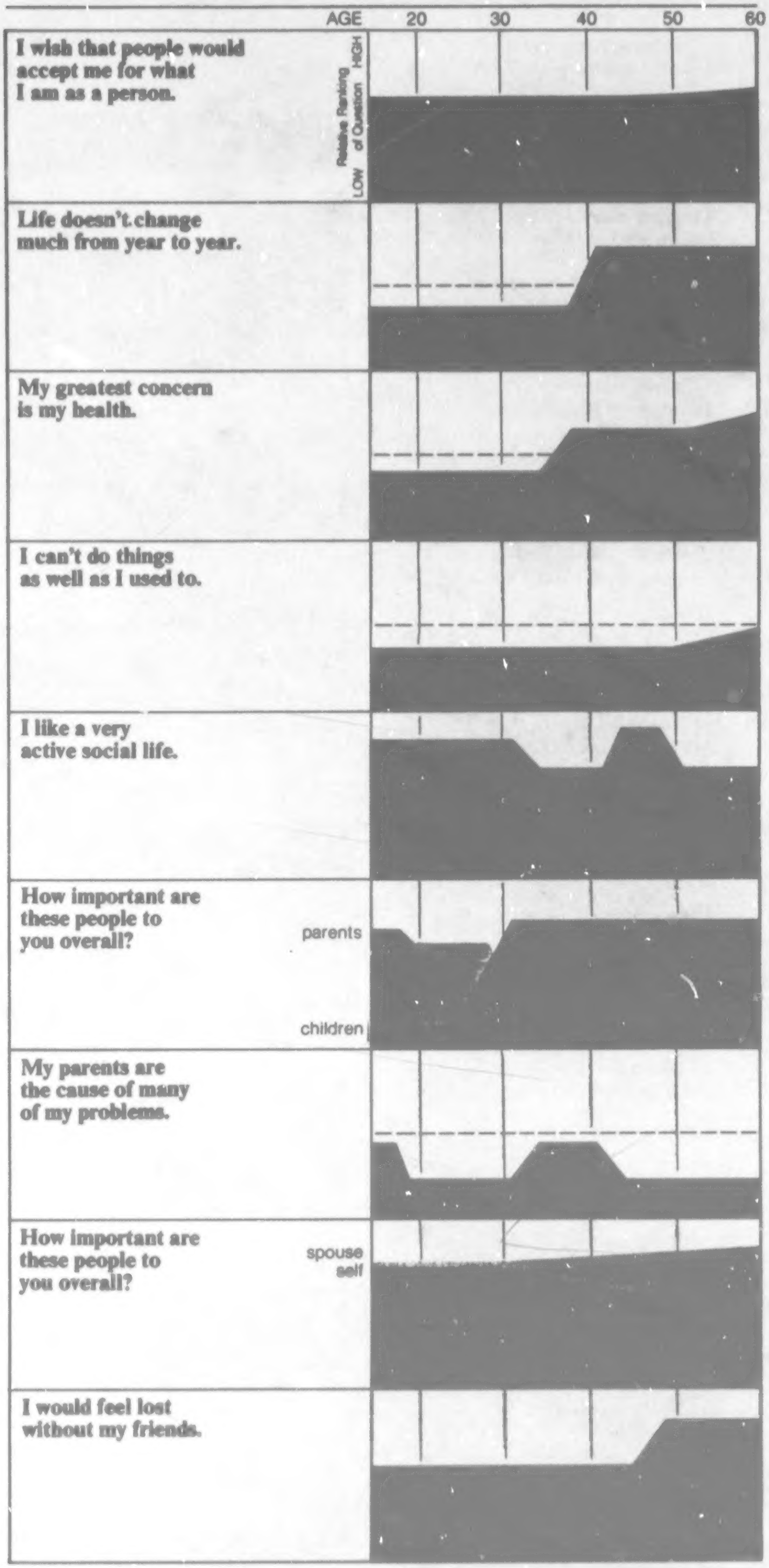
The 524 white, middle-class people who filled out questionnaires had seven distinguishable phases: 16 to 17, 18 to 21, 22 to 28, 29 to 36, 37 to 43, 44 to 50 and 51 to 60. There were approximately 20 people (divided equally by sex) for each year between 16 and 33, and 20 for each three years between 33 and 60, with women disproportionately represented over age 45.

For most questions, the rankings stabilized between the ages of 22 and 29, and remained steady throughout life. Certain questions, however, brought distinctly different responses from adjacent age groups, and it was these questions that defined the phases of adult life.

The responses of the 16- and 17-year-olds were almost identical to the stable patterns of those 22 to 29. The young people are still a part of their families, and they think of themselves more as family members than as individuals. In contrast, the 18- to 22-year-olds responded in a pattern quite distinguishable from that of the age set on either side of them.

As other studies previously showed, people in this age group have a unique psychology and subculture. They are more open to new ideas about the world, and are less repressive. When they get back to the mainstream of adult life in the 20s, they give the same pattern of pop-





ular responses that characterize the remainder of the population.

The Spring to the 40s. The late 20s are an interesting and active time. Marriage absorbs and reflects many of the stresses and strains, and the statement, "I wish my mate would accept me for what I am as a person" takes a sharp upward excursion between the ages of 28 and 32, while there is decreasing agreement that "For me, marriage has been a good thing." Children, on the other hand, become increasingly important during this time, displacing parents in priority as the person's focus shifts from the generation behind to the one ahead.

There is a clear focus on the family in the 30s. An active social life seems less important, while feelings about one's mate and offspring increase in significance. The 30s are a period of very active psychological change, a gathering of mental muscles with which to spring into the 40s. After age 29, there is a decline in the feeling that "I would be quite content to remain as old as I am now," a harbinger of the feeling in the early 30s that life looks a bit more complex and difficult than it did back in the roaring 20s.

In the early 30s, there is suddenly a feeling that "I don't make enough money to do what I want." Although this statement is undoubtedly true for almost everyone, the significance here is signaled by a sharp increase in the relative importance of this feeling to those in their early 30s. There is also an increasing tendency to feel that parents are the cause of many unsolved, stubborn personality problems that are being faced at this age.

The 40s seem to begin in the late 30s, and I distinguish a series of shared sentiments spanning the ages 37 to 43. In this age period, personal comfort decreases, and marital comfort remains at a low level. Between 40 and 43, there are several temporary departures from previous levels on statements dealing with personal comfort, suggesting that the 40s are an unstable and uncomfortable time. Later in the 40s both friends and loved ones become increasingly important. Children continue to be very important, and there is a sharp rise in regrets for "my mistakes in raising my children."

Money, so bothersome because of its insufficiency in the early 30s, becomes less important, and there is an accompanying feeling that it is "Too late to make any major change in my career." Coupled to the first downward shift in the feeling that "There's still plenty of time to do most of the things I want to do," these responses show a 40s phase of

The precise ages at which changes occur are a product of an individual's total personality, lifestyle and subculture.

reconciliation of what is with what might have been.

The sharp sense that "My personality is pretty well set" in the 41- to 43-year-old group establishes a dramatic beginning to the 44 to 50 period. In the span from 44 to 50, life settles down. With a slight sigh, there is an acceptance of the new ordering of things. Life is even. Not even better, not even worse, but simply even up.

Stability fraught with concern marks the 50s, and the concern is largely about time. With one's allotment of life more than half used up, people respond with increasing pessimism to the statement that "There's still plenty of time to do most of the things I want to do," and with increasing agreement that "I try to be satisfied with what I have and not to think so much about the things I probably won't be able to get." Concerns about health rise, and there is increasing agreement that "I can't do things as well as I used to do."

The Adult Butterfly. It is important to realize that the above descriptions are generalizations, reflecting the average of considerable personal variation. While I believe the sequence to be true for the majority of people, the precise ages at which changes occur are a product of an individual's total personality, lifestyle and subculture. How these changes are expressed and dealt with varies considerably from person to person; it's what you face, not how you face it, that is the common denominator.

The prevailing concepts of adulthood have obscured not only what is being faced, but also the fact that an adult needs to engage in any kind of continuing growth process at all. Like a butterfly, an adult is supposed to emerge fully formed and on cue, after a succession of developmental stages in childhood. Equipped with all the accouterments, such as wisdom and rationality, the adult supposedly remains quiescent for another half century or so. While children change, adults only age. My research demonstrates a need to overhaul our current view of adulthood, and to recognize that there is a developmental sequence in the early and middle-adult years.

Many researchers have previously pointed out isolated times of change in adult life, such as parenthood or the mid-life crisis. While helpful, none of these studies identifies the progression of phases that might link such changes together.

Yet I feel that there is such a progression. Childhood delivers most people into adulthood with a view of adults that few could ever live up to. A child's idealized image of an adult can become the adult's painful measure of himself. Without an active, thoughtful confrontation of this image, the impressions of childhood will prevail. An adult who doesn't undertake this thinking and confrontation lives out his or her life controlled by the impossible attempt to satisfy the magical expectations of a child's world.

Thoughtful Confrontation. The process of change means coming to new beliefs about oneself and the world. Habitually unorganized beliefs are more felt than thought, yet these beliefs must be thought about before they can be modified by experiences.

Many people hold themselves accountable for being perfect even when they have decided that the limiting conditions of a particular situation made the "perfect" act inappropriate, unwise, unnecessary or impossible. On one hand they believe that the decision that shaped their action was correct, but on the other hand they continue to feel (and on some level believe) that something is wrong with them for not having acted at some arbitrary level of perfection.

The belief that is felt—I should have done the impossible—is often not raised to a high enough level of consciousness to be thought about. The incomplete and inexact form of the thought is usually substituted, "Somehow I should have been able to do it better" and is left dangling, unexamined, and therefore unmodified.

The proper next step in a thoughtful confrontation would be, "I have always felt I should do things perfectly regardless of the circumstances; but this time *I decided* to do things differently for this and this reason." In that statement the conflict between the past and present beliefs are joined and resolution becomes possible between two *operative* and contending beliefs of the self. Neither of these operative beliefs represents mere intellectualized conclusions that are also called beliefs. They are valid and valuable parts of the self that have to be reconciled before a new value can be created that is reflective of the adult experience.

The process of confrontation involves thinking honestly about what one really feels. Modern psychologies have not been of much help in delineating the persistently obscure relationship between feelings and thinking. There has been a tendency to see feeling and thinking as two unconnected realms, yet my observations as a psychoanalyst are that thinking can and does modify feelings. I believe that it is through the constant examination and reformulation of beliefs embedded in feelings that people substitute their own conception of adulthood for their childhood legacy.

This process of thinking through is a cumulative one, and it should really come as no surprise that there are certain similarities in what people experience, and when they experience it. The passing of time sets the stage for several interacting processes that combine to produce the adult life phases I suggest. In addition to substituting an alternate reality for the childhood view, increasing age also brings changes in biological functioning, changes in the ages of one's parents and children, and changes in the cultural expectations about what a person should be doing.

My colleagues and I found that, in addition to the individualized process of changing childhood feelings about adulthood, there were enough experiences common to all adults to make it possible to find similarities in the way these people felt at different ages.

While children mark the passing years by their changing bodies, adults change their minds. Passing years and passing events slowly accumulate, like a viscous wave, eventually releasing their energy and assuming new forms in altered relationships with both time and people. By recognizing the patterns, we may gain some control over the forces by smoothing the transitions and muting the peaks and valleys of adult life phases. ◆

While treating patients at UCLA's psychiatric outpatient clinic, Roger Gould began to realize that people of similar ages had similar problems. This led him to study the stages of life he reports here. Gould took a B.S. at the University of Wisconsin, earned an M.D. at Northwestern, and then went back to school for a masters degree in public health at UCLA while he worked in the University Neuropsychiatric Institute. Except for a short stint in the Army, Gould has been at UCLA since 1960. He has directed the outpatient clinic and taught in the psychiatry department. Since 1970, he has had his own private practice of psychoanalysis and conducted research in the UCLA Department of Psychiatry.

MODULE V-A

ADAPTATION OF OLDER ADULTS: A TRANSITION MODEL

Nancy K. Schlossberg

Nancy K. Schlossberg received a baccalaureate in Sociology from Barnard College and a doctorate in Guidance and Personnel Administration from Teachers College, Columbia University. Now a professor in the Department of Counseling and Personnel Services at the University of Maryland, she also served as the first director of the American Council on Education's Office of Women and has taught at Wayne State University and Howard University.

Her research interests currently center on adult development, with particular emphasis on adaptation to transition. She has written extensively on the problems of women, sex stereotyping, and age bias. In addition to teaching and research, she has been active in developing training materials and coordinating workshops. She currently serves on the Board of Trustees of the National Manpower Institute.

ADAPTATION OF OLDER ADULTS: A TRANSITION MODEL

Rationale and Objectives

All adults continuously make transitions in family, work, and community roles, though not necessarily in any age-graded manner. These transitions do not occur in sequential order, nor does everyone experience the various transitions in like manner. Given this variability, a significant question for the counselor arises: Since individuals react so differently, how can we understand and help older adults adapt to the inevitable transitions of aging?

This module is intended to identify those factors that enable older adults to cope effectively with the inevitable transitions they face. To accomplish this, a framework will be presented that will help the counselor analyze a client's adaptation to and develop differential interventions for the many transitions characteristic of older adulthood such as relocation, declining health, remarriage, retirement, career change, and grandparenthood. It is hoped that an understanding of this transition model will enable the counselor to better understand these and other significant transitions of older adulthood, which are explored in more depth in the following two submodules and elsewhere in the syllabus.

The objectives of this module include the following:

(1) To present knowledge about the concepts "transition" and "adaptation."

(2) To present a way to analyze adaptation to any transition.

(3) To offer guidelines for intervention that will ease adaptation to any transition.

(4) To offer counselors a perspective on their own adaptation to the inevitable transitions accompanying adulthood.

Content

A TRANSITION MODEL FOR UNDERSTANDING OLDER ADULTS

The following model is premised on the notion that older adults as a group are in a state of transition; that work, family, and community roles are changing, but at a confusing and uneven pace; and that individual adults are at different points of transition and encounter different problems. The model makes no assumptions about what specific stance clients should be encouraged to take or what decisions they should make; it offers instead a way for counselors to assist clients to look at and understand their particular situation and to take responsibility for it.

The counselor does not, of course, deal with older adults as a group; the counselor deals with individual clients who have specific problems. Most of these problems can be analyzed within the context of the transition model. Throughout their lives, adults make transitions continuously: They get married, have children, get divorced, are widowed, change jobs, retire, move, have operations or illnesses, and so forth. The model for studying adults in transitions has three major components (Figure 1). To help the client going through a transition, the counselor must have an understanding of transitions in general. The counselor also must be able to analyze the three kinds of factors that influence an individual's adaptation to transition: the characteristics of the transition itself, the characteristics of the pre- and post-transition environments, and the characteristics of the individual experiencing the transition. Finally, the counselor should be able to assess the individual's adaptation to the new environment.

Transition

The term "transition" can be used to cover a variety of events, and thus it is difficult to define precisely. Perhaps the best general definition is that of Parkes, who regards a transition as any major change requiring the "individual to restructure . . . ways of looking at the world and . . . plans for living in it" (Parkes 1971, p. 102). The crucial element is that the change requires "the abandonment of one set of assumptions and the development of a fresh set to enable the individual to cope with the new altered life space" (Parkes 1971, p. 103).

One way of examining a transition is to assess the difference between the pre-transition and post-transition environments, which may have a profound effect both on assumptions about the self and the world and on relationships in the family, work, and community. To illustrate: The pre- and post-transition environments may differ very little if one moves from one apartment to another in

FIGURE 1

A Model for Analyzing People in Transition

Transition	Factors Influencing Adaptation to Transition	Adaptation
Events such as: job change marriage residential move major illness retirement death of a loved one birth of a grandchild institutionalization	Characteristics of particular transition: event itself degree of stress source: internal vs. external timing: on-time vs. off-time effect: positive vs. negative duration: permanent, temporary or uncertainty role: increment or deficit degree of stress	Movement through phases following transition: pervasiveness through reorganization level of current functioning and level of life satisfaction
Degree of difference between pre and post transition environment: assumptions about self and world relationships in family, work, and community	Characteristics of pre- and post-transition environments: personal and physical interpersonal support systems —intimate relationships —family cohesiveness and adaptability —network of friends institutional supports environmental context	
Opportunity for growth or deterioration	Characteristics of Individual sex and sex role identification age, social class and health psychosocial competence —attitudes toward and self —outlook: optimism vs. pessimism —coping orientation previous experience with crisis perception or expectation	

the same neighborhood unless that move is part of a more profound transition, as when separating from a spouse, whereas the differences involved in a move from home and community to a nursing home may be great enough to precipitate "culture shock."

Transitions can apply to external events like moving to a nursing home, or they can apply to internal events like the sudden perception of oneself as middle-aged or old. In the latter case, chronological age, however, is not the determinant, since people from different social classes assign youth, middle age, and old age to different chronological ages. For example, an assembly line worker sees old age as starting earlier than a bank president. Also, individuals from the same social class and same age vary greatly in the way they define themselves (Neugarten, 1968 p. 144).

Any transition, whether an actual event like a move or a perception like I'm getting old, can be an opportunity for either growth or deterioration (Moos & Tsu 1976, p. 13). For example, the transition of vocational retirement becomes for some people a stimulus to develop new interests and take up new activities and for others a dead end marked by inactivity, boredom, and feelings of worthlessness.

Factors Influencing Adaptation

What determines whether a person grows or deteriorates as the result of a transition? Why do some people adapt with relative ease while others seem unable to do so and may even suffer such severe strain that they become debilitated? To answer these questions and to intervene in ways that will be helpful to the client, the counselor must examine three kinds of mediating factors: the characteristics of the particular transition, environmental characteristics, and individual characteristics.

Characteristics of Transitions. As already indicated, many kinds of life events can be classified as transitions, but most transitions can be described using a common set of variables: source, timing, affect, duration, degree of stress, and role change. Let us take the example of retirement, a kind of transition that has become a fact of life for many Americans. Only recently has legislation been introduced in America to raise the age of mandatory retirement, while in Russia laws were enacted to provide incentives to keep people working by providing pensions plus full salary.

One dimension of a transition that helps to determine its impact is the source: internality versus externality (Lipman-Blumen 1976, pp. 237-238). Is the transition a matter of choice on the part of the individual, or was it forced on the individual by some other person or some external agency? A 60-year-old man or woman may feel forced to move if his or her company moves. This "choice" may be made largely out of fear that age discrimination will prevent the person from securing another job. It seems reasonable to assume that the more internal the source of the transition, the easier the transition will be and the more likely the individual is to adapt readily. To have control over the changes in one's life is obviously to be desired, though not always possible.

The second characteristic of a transition is its timing: on-time or off-time. According to Neugarten, "there exists a socially prescribed timetable for the ordering of major life events" (1977, p. 34), and most adults have built-in "social clocks" by which they judge whether they are "on-time" or "off-time." To be "off-time," whether early or late, carries with it social penalties. Moving at the time one enters the senior year in high school is "off-time," moving away from family when newly married is "on-time." Although residential moves are not a kind of transition that is socially prescribed, many other kinds of transitions — such as getting married, going to school, taking a job, retiring — are linked very definitely with age. Generally speaking, it is easier to adapt to an on-time transition than to an off-time one. According to a study quoted by Neugarten, "70 percent of persons who retired as planned were content . . . compared with those who retired unexpectedly because of poor health or loss of job" (1977, p. 44).

The third characteristic of a transition is its affect: positive or negative. Some kinds of change are welcomed by the individual: remarrying at 65, being promoted, becoming a grandparent. These transitions usually generate feelings of excitement and pleasure. Other changes are feared and dreaded: losing a job, becoming widowed, being forced to retire. Most changes probably have elements of both positive and negative affect. Thus, one may anticipate a residential change with pleasure, as a chance to live in a larger and more comfortable house or in a more pleasant neighborhood or city, but at the same time feel pain over leaving neighbors and friends and fear over facing the unknown. Becoming a grandparent may be a source of joy and satisfaction but might also contain elements of discomfort and irritation, especially if children and parents disagree about the grandparents' role.

Whether a change is regarded as permanent, temporary, or uncertain, its duration is a fourth characteristic that helps to determine how an individual perceives and adapts to a transition. A health problem that is painful and unpleasant may be more easily borne if the individual is assured that it is of limited duration: as when one enters the hospital for surgery that one knows will be minor and will have no lasting effects. In the case of many individuals, there is great ambiguity and uncertainty: has the cancer been arrested and if so for how long? Will the temporary disability go away? As one woman said, "Will I ever be well again?"

Finally, a transition can be characterized by the degree of stress involved. Holmes and Rahe (1967) view stresses as those life changes requiring adjustment. By this definition, any transition, whether positive or negative in effect, involves some degree of stress.

The Social Adjustment Rating Scale (Holmes & Rahe 1967) is an instrument that assigns numerical values to different kinds of life events. "Death of a spouse" ranks at the top of the scale, whereas such items as "vacation," "Christmas," and "minor violations of the law" are at the bottom of the scale. Generally speaking, the smaller the amount of stress involved, the easier the individual can adjust. One must bear in mind, especially with older adults, the additive nature of stress. To experience a number of changes within a given time period, whatever the nature of the changes, may be detrimental to physical and mental health. For instance, an individual retiring is often adapting to much more than the event "retirement." S/he might also be moving, changing friendships, losing some kinds of status and gaining other kinds, changing income level, etc. Thus an event needs to be viewed in context of multiple stresses incurred.

Changes in role need to be assessed in terms of whether the transition involves an increment or deficit. One example of a transition that may involve vastly altered assumptions about self and world is the birth of the first grandchild; this is also an example of a role increment (Lowenthal, Thurnher, Chiriboga & Associates 1975), whereby one adds the role of grandparent to one's repertoire of roles; other examples of role increments are getting remarried, becoming a student, assuming active community roles. Retirement from the world of work is another kind of change that has considerable impact on assumptions about self and relationships. This can be an example of a role deficit, since one is losing the role of worker. Other examples are getting divorced, being widowed, becoming ill, having one's income reduced.

Characteristics of Environments, Pre- and Post-Transition. As mentioned earlier, it is possible to assess the impact of a transition by looking at the degree of difference between the pre- and post-transition environments. The three most salient characteristics are interpersonal support systems, institutional supports, and the environmental context (Schlossberg 1978).

Interpersonal support systems include intimate relationships, network of friends, and family cohesiveness and adaptability. Interpersonal intimacy — a relationship characterized by similarity, reciprocity, and compatibility — has been found to "serve as a resource against life's crises" (Fiske & Weiss 1977, p. 30). For instance, data show that to be widowed is more traumatic for men than for women for a number of reasons. One possible explanation offered by Fiske and Weiss is that men are less likely to share their inner world with others; when they lose their wives, they literally lose their best friends (1977). Men's inability to form close relationships with other people may also be a factor in their shorter life expectancy. Women are more likely than men to have close interpersonal relationships with someone other than the spouse — with a "best friend," for instance. Because of their greater capacity for mutuality, women may be better able than men to adapt to the loss of a spouse.

"Network of friends" obviously encompasses a much broader range of people, from fairly casual acquaintances to people seen frequently on social occasions. Women tend to have more friends, to be more deeply involved with them, and to have more complex perceptions of them than men do (Weiss & Lowenthal 1975). Married couples typically have two sets of friends: individuals of the same sex and similar interests whom they may have met before marriage and "family friends," with whom they form ties on the basis of the husband's work. Weiss (1975) has pointed out that when couples separate or divorce, the network of family friends is often lost to the wife, who thus suffers greater social isolation than the husband. A residential move following retirement often involves a break with the network of friends, adding to the sense of loss and distress. On the other hand, retirees often look forward to a move, if it is to a supportive community.

"Family cohesiveness & adaptability" is, according to Lipman-Blumen (1976), crucially important during a period of transition. A person will cope differently with that transition depending on whether s/he is part of a family or not, and if so, on how close-knit and flexible that family is.

The second kind of environmental characteristic that influences adaptation is the kind of institutional support an environment offers. Institutional supports may be outside agencies a person can turn to for help and support, e.g., community services, mental health facilities, schools and libraries, or volunteer organizations, or they may be rituals that help to define and legitimize a transition. A funeral is such a ritual. When someone is ill, what sick leave benefits exist; if someone is disabled, what are the institutional arrangements? If a building has no elevators and ramps obviously someone in a wheel chair could not work there. When an agency has a reduction in its work force what support is offered?

A major issue for the elderly who become ill centers around living arrangements. Can they remain independent and at home; are they placed in an institutional setting; is this placement voluntary? Morton Lieberman (1975) studied individuals before and after moving to a nursing home. He found that adjustment depended on the similarity between one's previous home and the institution. Extending this line of reasoning, one might assume that if an older person moves from a rural to an urban setting the adjustment would be more difficult than if the pre/post physical environments were similar.

Characteristics of the Individual. No matter how a transition is defined on some objective scale, an individual's adaptation to it will depend on the characteristics of that individual, most notably sex-role identification; age, social class, and health; psychosocial competence; and previous experience with the transition.

With respect to sex-role identification, males and females are socialized to different attitudes and behaviors. The extent to which the individual has internalized these norms may play an important role in his or her ability to adapt. Thus, the woman who conforms to the "feminine" stereotype — dependent, passive, conforming — will find herself at a disadvantage in adapting to transitions, like divorce or widowhood, that require her to be independent, assertive, and self-reliant. Conversely, the woman who has defied the stereotype and led an independent life may find the transition of marriage difficult, particularly if she is called upon to sacrifice her own desires and needs to her husband's as is often the case with a residential move. Counselors must be able to assess the degree to which the individual man or woman identifies with the traditionally prescribed sex role. This is not to suggest that the goal of counseling is to move women from a vicarious to a direct-achievement orientation or men from a direct to a vicarious achievement mode but simply that the counselor must take the person's orientation into account. (See Lipman-Blumen & Leavitt 1977.) For example, women of 50 or 60 were socialized during adolescence with different sets of norms than are junior high school students today. Historical differences in life-style are important to consider (Neugarten 1977). A woman who has always functioned vicariously and suddenly finds herself the sole support of her family is forced by circumstances themselves to make this switch to a more direct achievement orientation; for other kinds of transitions it is unnecessary.

It is widely recognized that health is crucial to one's ability to adapt to any transition. A crucial task of aging is what Robert Peck defines as choosing between "body transcendence" and "body preoccupation" (1968, p. 218). Interestingly enough, health is subjective as well as objective. By constructing an index to compare a person's self-health rating with degree of incapacity, it was possible to compare people cross-culturally. Many people over 80 in the same "health boat" react differently. In general, men over 80 report better health than women over 80, those from Great Britain define themselves as healthier than their counterparts in Denmark and the United States. Some people are "health pessimists," some "health realists," and others "health optimists" (Shanas; Townsend; Wedderburn; Friis; Milhov; & Stehouwer 1968, pp. 217-218). The authors did find, however, that men right after retirement are less optimistic about their health than earlier or later (p. 218).

Reactions of men aged 37 to 67 to a health condition like a heart attack differed with the individual's age and social class (Rosen & Bibring 1968, pp. 201-211). The fifty-year-old group became most depressed and difficult as patients, according to their nurses. The authors suggest that a "heart attack theoretically accentuates the very issues with which he has been actively struggling" (p. 207) — his aging and his fear that he must shift from an active to a passive role. Reactions also varied according to social class. White collar workers became more anxious and depressed than blue collar workers. Part of the difference stemmed from the knowledge and questioning attitude of white collar workers. They knew more about the ambiguities of the situation, whereas the blue collar workers accepted concrete causes and concrete rehabilitation plans more readily than white collar counterparts.

Is age the crucial variable in understanding issues of adulthood? The two theorists best known for their differing views on the subject are Daniel Levinson, an exponent of the age-graded theory, and Bernice Neugarten who sees the concerns of adults relating to timing and stage rather than age. The facts do not necessarily make the difference, but perceptions of one's situation, or what Neugarten (1978) refers to as expectations about one's situation in relation to one's age. Many older individuals feel isolated and lonely; some do not. If a person was socially isolated over a life course, perhaps s/he would expect sparse social interaction. If, on the other hand, someone had had a very active social and family life until reaching 80 and then found few opportunities for contact, the individual would more likely be stressed and depressed. Thus, it is not being 75 or 80, but being 75 in relation to one's actual resources and one's perception of resources.

Several recent studies have attempted to define and measure psychosocial competence (also referred to as "autonomy" or "maturity"), a key element in the adaptation of adults. For instance, Tyler, using an instrument called the "Psychosocial Behavioral Attributes Scale," identified as major components of competency: attitudes toward the self, including a favorable self-evaluation, a sense of responsibility, and the ability to introspect (Lieberman 1975, p. 156); attitudes toward the world, including a moderate optimism in their ability to interact with the world and thus to influence events; and such behavioral attributes as having an "active coping orientation, high initiative, realistic goal-setting, substantial planning, forebearance and effort in the service of attaining goals, and capacity for enjoying success, suffering failure, and building from both" (Tyler n.d., p. 5). They have identified older persons who scored high on competency to serve as resource and support for other older persons in the community.

Ability to cope may be closely related to another characteristic of the individual: previous experience with a transition of a similar nature. People who have in the past successfully adapted to illness may have developed strategies that will assist coping with another illness in the present; or their past experience, if very negative and frightening, may increase the stress of the present transition and hinder the individual's more rapid progress through the adaptive process.

Adaptation

What constitutes effective adaptation to a transition? Like transition, the term adaptation has a variety of meanings. Some writers use it to mean personal growth and development, others to mean homeostasis. Adaptation can be measured in two ways: as level of current functioning, and as movement through the phases following the transition. Specifically, level of current functioning refers to "overall mental health, . . . level of life satisfaction and self-esteem, adequacy of social functioning, maintenance of integrated, consistent self-concept, adequacy of meeting central inner task" (Lieberman 1975, p. 144).

A more dynamic approach to measuring adaptation involves assessing the individual's movement through the various stages following a transition; that movement is typically along a continuum from pervasiveness, during which the change permeates every part of one's existence and consciousness, to "boundedness," at which point the change has been contained and integrated into the self (Lipman-Blumen 1976, pp. 241-242). For example, Kubler-Ross (1969) describes five stages experienced by people who realize they are dying: denial and isolation, anger, bargaining, preparatory depression for impending loss, and acceptance. Bereavement over the death of a close friend or relative similarly moves from "almost global denial or 'numbness,'... bitter pining and frustrated searching,... succeeded by depression and apathy... with a final phase of reorganization when new plans and assumptions about the world and the self are built up" (Parkes 1971, p. 106).

Each transition has its own typical pattern or sequence of stages moving from an "acute stage in which energy is directed at minimizing the impact of the stress, to a reorganization phase in which the new reality is faced and accepted" (Moos 1976, p. 14). One function of the counselor is to help the client understand the typical sequence of phases associated with various kinds of transitions, to identify the phase that the client has reached, and to suggest strategies for progressing smoothly to the stage of boundedness and integration.

Implications for Counselors

Knowledge about transitions and adaptation to transitions will help individuals assess what they are going through, how long it will last, and what coping mechanisms to use. By using this model, it is hoped that the counselor can help clients gain insight into an understanding of their problems. Very often, adults who experience difficulties coping with transitions are doubly disadvantaged because they feel that, as adults, they should not have such difficulties. They believe that they should be "mature," "competent," and able to make whatever adjustments are required of them. Particularly with older adults, they might fear being labeled senile. For example, a 35-year-old reacts differently to a memory loss than a 70-year-old.

The transition model can give assurance that such difficulties are, if not universal, at least widespread; that the problem is susceptible to analysis; that virtually all transitions have similar patterns. For instance, it may be helpful for a client and counselor to realize that virtually any change is ambivalent in its effect: that it has negative as well as positive aspects.

To restate, the model can provide counselors and clients with a way to analyze the difficulties a particular individual is having adapting to a specific transition, guidelines for intervention to ease adaptation to any transition, and a perspective on adaptation to the transitions accompanying adulthood.

ANALYSIS OF DIFFICULTY BETWEEN TRANSITION AND ADAPTATION

This model offers a way for counselors and clients to analyze the missing link(s) between transition and adaptation. Is the problem related to the nature of the particular transition, to the difference between pre- and post-environments, or is the difficulty related to the individual? For example, a person will react differently depending on whether the transition is permanent, on-time, and a role increment or deficit. A woman who becomes a grandparent at 40 when her daughter is 16 and unmarried will obviously react to the transition of grandparenthood differently from the woman of 65 whose daughter has her first child at 40. Again, what is significant is not the specific transition—retirement, grandparenthood—but the individual in relationship to the transition. For example, if counselor and client realize the particular difficulty is with the timing of the event, they will plan intervention accordingly.

The individual's difficulty might, however, be connected with the pre/post environment, especially in regard to support systems. Two women widowed "on time" might react very differently because of the difference in their support systems. One lived in a community with a great deal of interaction and connection between neighbors, the other lived in an environment with friends not geographically available. The support system for the first was much more inclusive and helped greatly ease the loss.

Institutional support cannot be underestimated. An example is the case of an energetic entrepreneur who became ill with melanoma. He was turned down for a major grant when the foundation learned of his illness. Fortunately, his oncologist at the National Institute of Health wrote a convincing letter about the man's ability to carry out his grant. Reactions of institutions through their personnel can provide needed support or can foster devastating consequences to the involved individual. Concerned counselors can negotiate for humane support.

Adaptation to any transition is further mediated by the individual's makeup or what we have called "psychosocial competence." Some people are more "together" than others; some are in better health; some are members of a social class with available options; some are socialized to be independent and others are socialized to be dependent. What the individual brings to a transition cannot, in any way, be ignored. To assume, however, that everyone who is depressed during a transition is neurotic is often a result of bias or lack of information or understanding. While it might be uncomfortable, being depressed, anxious, or the like during periods of transition, particularly those characterized by multiple changes, is a rather normal response to stress-producing situations. How one copes with this stress is the important factor. This is where counselors can be of invaluable assistance.

GUIDELINES FOR INTERVENTION

Intervention to ease adaptation will depend on the specific difficulty a particular person is having. Different counseling strategies might be employed depending on whether the transition is temporary or permanent. For example, a person disabled for 6 months by a slipped disc needs different help from a person permanently disabled. A person who moves after retirement into a new community with no network of friends might be encouraged to seek out support groups by forming what Weiss calls "supplementary relationships" (1974, p. 192) during the transition. A person who has had a life pattern of poor psychological adjustment might be helped by psychotherapy. Thus, the intervention would depend on which factors were identified as the problem for the individual.

In addition to differential intervention strategies, older adults can benefit from both support and cognitive understanding of what they are experiencing. In studying ways to help those separated through divorce or death, Robert Weiss explained the value of providing a cognitive framework. He classifies stress as crisis, transition, and deficit (1975). A crisis is a sudden, severely upsetting situation of limited duration that requires summoning all of one's resources. People in crisis often report feeling suspended or numb. An example of a crisis is an accident or the sudden onset of a major illness. When the crisis passes, the affected individual either returns to "normal" or enters a transition state. This period is often marked by confusion and uncertainty as the person attempts to rearrange his/her life. People in transition states are particularly likely to benefit from counseling help, because the decisions they make at this point could profoundly affect the course of the rest of their lives.

The end of a transition state is usually marked by a new life organization and personal identity. The new life situation is either satisfactory or not; if it is not satisfactory, then the individual enters into a deficit situation. For example, a widow or widower may find that she or he has continuous difficulty in living alone. In contrast to a crisis, which is short-lived, a deficit situation tends to be long-lasting.

To individuals experiencing a crisis, immediate support seems to be the best kind of help. The helper (who may or may not be a professional person) communicates empathy, understanding, and a readiness to provide whatever service is possible to help the individual through the crisis. The helper needs to be a trusted figure who is competent, devoted, and objective (Weiss 1977). Such support is also helpful to those in transition states and deficit situations, but they can benefit from other kinds of help as well. Helping an adult cope with a life-threatening illness of a spouse calls for immediate support rather than strategies like exploring alternatives for the future, which might be more appropriate at a later time.

People in transition must find new ways of managing their lives; they may be helped by cognitive materials that will provide a framework for understanding the new situation. For instance, the new widow or widower may need help in managing finances or in locating housekeeping or meal services. People in transition states may also be grappling with emotions that they do not understand and may be helped by cognitive understanding of their emotions.

Knowledge that it is normal to be upset when control over one's destiny is wrested from one is helpful. Knowledge that transitions which occur when expected (retirement at 65 not 58) are easier to deal with than those occurring off-time helps in one's adaptation. So often, counseling training, while stressing the value of developing active listening or reflecting skills, overlooks the value of providing accurate information in appropriate situations — a response that can be very helpful and reassuring when timely. In such instances, providing accurate information can be most therapeutic. Take the case of a man at age 55 who was retired because a plant relocated when he was unable to move because of his wife's job and children's senior high school status. This situation might depress the individual, make him feel worthless, on-the-shelf, and over-the-hill. In transitions like this one, the counselor might give support and also provide a cognitive framework so that the individual knows what s/he is going through. Weiss (1977) does state that people can be helped by "information which may extend understanding."

People in deficit situations have reached a new period of stability, even if it is unsatisfactory. Short-term help is of little value to them. They need a continuing, problem-focused support system. For instance, older parents living in nursing homes may require continued help with the problems they encounter. Becoming acquainted with other people in the same situation as themselves may be of practical as well as psychological value, as mutual problems and possible solutions are shared.

A PERSPECTIVE ON ADAPTATION

Defining adaptation as the process of moving from pervasiveness to boundedness for any salient transition provides a time perspective — adaptation takes time and has a course to follow. Normalcy includes mourning for a loss or focusing on a joyful addition to one's life. Often people who lose a child — probably the most painful loss of all — complain that after a brief time their friends become impatient with their need to continue focusing on their loss. This model hopefully inspires a generosity toward oneself and others that normalcy is not denial and rapid adjustment.

Besides a point of view about transitions that have occurred, counselors can offer help to adults facing transitions with adequate planning and preparation of clients anticipating retirement, parenthood, grandparenthood, etc. As Parkes writes, "adequate advance planning and preparatory training can transform what is potentially a major change in the assumptive world into a quite minor transition" (p. 113). Levine points out that the single most effective strategy for coping with crisis is "seeking and utilizing information about a threatening situation" (1976, p. 26). Preretirement planning programs are based on the notion of advance planning.

CONCLUSION

Counselors should learn the dimensions of the content of a particular crisis, whether moving, an operation, or institutionalization. Knowledge of specific crises older adults encounter will enable the gerontological counselor to better hear what the counselee is saying. Counselors should understand the uniqueness of each individual and the fact that how a particular individual reacts to one crisis does not necessarily predict the way s/he will react to another crisis. Rather, reaction and adaptation to a crisis will depend on many factors. This discussion identified the specific phases through which persons in transition might progress and the variables predictive of successful progression. It is hoped that the conceptual framework provided in this model will help gerontological counselors better understand and assist their clients who are experiencing any of the multiple transitions of older adulthood as discussed in other modules.

Individual/Class Activities

Each student chooses one transition common to older adults as described in Modules II, IV, VB and VC and interviews three people who have experienced the transition (3 people who have retired, moved, become widowed, or become grandparents). The helper/counselor/interviewer can use the following worksheet as a guide to uncover how the three individuals experienced a transition and to determine the particular individuals' degree of adaptation. Whether these forms are completed during or immediately after the interview should depend on the counselor's own philosophy and the client's preferences. If the forms are completed during the interview, the counselor should be thoroughly familiar with the form so that attention is focused on the interviewee and not on interpreting the forms. If the forms are left until after the interview, the counselor should complete them as soon as possible so that elapsed time does not interfere with retention.

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Evaluation and Assessment

1. On the basis of the worksheet, what interventions would you suggest for each person? Would you be able to suggest programs that might help others facing this transition?

2. Evaluate the interview worksheet. Did it help get at the issues you felt the interviewee really was experiencing? Did it provide you with a greater perspective for analyzing and approaching the client's situation? If so, specify.

3. Based on this material, discuss some ways in which a counselor could develop a group counseling program for a specific target population, i.e., preretirees, widows, career changers.

4. Discuss the relationship between the factors that influence transition, the characteristics of the transition itself, and the characteristics of the individual experiencing the transition. Reflecting on a past transition of your own, determine which of these factors was the most important variable influencing your successful adaptation to the transition.

Interview Worksheet

Transition Selected:

Factors influencing client's adaptation (Check number that is applicable on continuum)

1. Transition					
Source:	1 Internal	2	3	4	5 External
Timing:	1 On-time	2	3	4	5 Off-time
Affect:	1 Positive	2	3	4	5 Negative
Duration:	1 Temporary	2	3 Permanent	4	5 Uncertain
Degree of Stress:	1 High	2	3	4	5 Low
Role:	Increment	Deficit			
2. Pre/Post Environment					
Intimate relationships					
Current:	1 High	2	3	4	5 Low
Pretransition:	1 High	2	3	4	5 Low
Network of friends					
Current:	1 High	2	3	4	5 Low
Pretransition:	1 High	2	3	4	5 Low
Family cohesiveness					
Current:	1 High	2	3	4	5 Low
Pretransition:	1 High	2	3	4	5 Low
Institutional support					
Current:	1 High	2	3	4	5 Low
Pretransition:	1 High	2	3	4	5 Low
Physical environment similarity					
Pre/Post	1 High similarity	2	3	4	5 Low similarity
3. Individual characteristics					
Health impairment:	1 Low	2	3	4	5 High
Check:	1 Health optimist	2	3 Health realist	4	5 Health pessimist
Psychosocial competency					
Attitudes toward self:	1 Favorable	2	3	4	5 Unfavorable
Outlook:	1 Optimistic	2	3	4	5 Pessimistic
Coping orientation:	1 High initiative	2	3	4	5 Passive
Previous experience with similar crisis:	1 Enabling	2	3	4	5 Disabling
Expectations about transition:	1 Expected	2	3	4	5 Surprising

ADAPTATION:

On the basis of the interview rate person's adaptation on a 1 to 5 scale. List numbers of 1s, 2s, 3s, 4s, 5s.

1.
2.
3.
4.
5.

List degree to which interviewee is pervaded by transition

5 = High
1 = Low

People experience many different feelings from the time they anticipate a transition until long after it occurs. Which of these objectives describe your feelings?

	Pretransition	Right after transition	Now
Denial			
Anger			
Sadness			
Depression			
Joy			
Happiness			
Apathy			
Confusion			
Introspection			
Excitement			
Challenge			
Bright			

Final Question

If you were asked to write an article for the Sunday Supplement of the Post describing this event from your point of view what would you say—what would you highlight?

COUNSELOR'S INTERVENTION:

1. On the basis of the person's degree of adaptation and particular problem areas, list several strategies for helping individual.
2. On the basis of the worksheet, what interventions would you suggest for each person? Would you be able to suggest programs which might help others facing this transition?

MODULE V-B

POTENTIAL CRISIS SITUATIONS FOR OLDER PERSONS: PRERETIREMENT, RETIREMENT, LEISURE, RELOCATION, HOUSING

Harold C. Riker

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POTENTIAL CRISIS SITUATIONS FOR OLDER PERSONS: PRERETIREMENT, RETIREMENT, LEISURE, RELOCATION, HOUSING

Rationale and Objectives

As men and women grow older each faces the process of aging and the inevitability of dying. These two facts may produce crisis situations for some individuals who are unable to adjust or adapt to changing life conditions. Such crisis situations may occur during the preretirement period when the person is considering retirement plans, at retirement or during the first year thereafter when the person is attempting to use leisure time, or when the person is making decisions about changes in living arrangements. Many people deal with major transition periods in their life with minimum difficulties, but some do not and these individuals need help — sometimes major help — from counselors.

Counselors should be prepared to recognize that crisis situations can provide significant opportunities for facilitating attitude and behavior changes that can lead to further individual growth. In short, crisis points in the pre- and postretirement periods can and should be used for individual development.

Counselors' points of view toward issues related to retirement are of tremendous inportance to their effectiveness in working with individuals who are moving toward retirement. An essential perspective for counselors and those they counsel to have is that the human life span includes a number of periods, each of which involves certain developmental tasks, new opportunities, and certain losses. It should also be understood that there is individual continuity over the life span.

Counselors can be especially useful in helping preretirees and retirees review their personal value systems and make appropriate adaptations. The significance of such an effort is suggested by the possibility that retirees soon may have as much as one third of their lives to live after retirement (Butler 1975). How they live during these years is important both to themselves and to society.

The objectives of this module are to provide counselors with information and suggestions that may be helpful to them as they work with preretirees and retirees who may be facing vital decisions affecting their present and future well-being. These objectives are:

1. To enlarge the understanding of retirement as an important stage in the life cycle.

2. To consider preretirement as an opportunity for preparation for changing life styles.

3. To view leisure time as providing opportunities to find new ways for meeting significant developmental needs.

4. To consider the options for postretirement residence.

5. To clarify the purposes of adult congregate living facilities and nursing homes as they meet specialized needs at various life stages.

Content

ISSUES RELATING TO RETIREMENT

The realities of retirement are often shrouded in myth and stereotype. Important as the concept of individuality is to American society, this concept is not extended to those who retire. Upon retirement, people are suddenly consigned to a faceless society, are regarded as unimportant and ready for death. Counselors need to learn more about retirement and the issues involved.

What Is Retirement?

The term "retirement" developed with the industrialization of society and means, in a sense, the opposite of holding a full-time job. Retirement is not properly the opposite of work because retired people do work, nor is it the same as unemployment. Atchley (1976) describes it as

> a condition in which an individual is forced or allowed to be and is employed less than full-time (whatever that may mean in his particular job) and in which his income is derived at least in part from a retirement pension earned through prior years of service as a job holder (Atchley 1976, p. 1).

In addition to being part of the occupational cycle, retirement can be described as "an event, a process, or a social role" (Atchley 1976, pp. 3-4). As an event, it may or may not involve a ceremony, but it is likely to mark the point in time when a familiar job ends. At the same time, retirement is a process, in that it is viewed over a period of time and understood by many workers, intellectually if not emotionally, as being an inevitable consequence of employment. In terms of the event and the process, retirement is likely to emphasize finality with no future.

As a social role, however, retirement can assume an ongoing quality and bring with it the realization of new responsibilities and new challenges. This role and the complex factors involved in dealing with it are discussed at length in the following sections.

When Is Retirement?

The age of 65 has long been accepted as the age for retirement. It was supported by Social Security legislation adopted by Congress in 1935; 65 was used as the age when males could receive retirement benefits. As of 1978, however, federal law banned mandatory retirement before 70 for workers in the private sector and at any age in the federal government. Certain exceptions were made in the case of teachers and business executives. Given their successful performance of assigned duties, therefore, some people could conceivably continue working throughout their life span. In terms of human rights, federal and state legislation is moving in the direction of enabling all citizens to work as long as they maintain the will and necessary skills. On this basis, increasing numbers of people may never retire but continue working as long as they live. Some do so now. At the same time, trends have gone in the opposite direction. From 1890 to 1970 the percentage of males 65 and over in the labor force dropped from 68.3 to 25.8 (Atchley 1976).

The U.S. Civil Service Commission has encouraged earlier retirement by means of rules that enable employees to retire on completion of 25 years of service or, if 50 and over, with 20 years of service (Butler 1975). U.S. military personnel can and do retire after 20 years of service, sometimes at ages younger than 50. Industrial firms and labor unions have joined together to make it possible for individuals to retire at 56 or earlier. Kimmel (1974) speculates that further developments in U.S. technology could make retirement possible at age 38. Earlier retirement trends seem likely to expand the needs for counselors to provide assistance to individuals seeking second or third careers or part-time employment.

The point is that retirement age already varies widely and may vary even more in the future. No longer can all retirees be lumped into the same age category, if they ever could be. In fact, the probabilities are that age distinctions between those who work full time and those who are primarily retired will become blurred and of little consequence.

Biological Factors. Two elements discussed here are the physiological aging process and the results of disease. Important organs and systems of the body deteriorate with time; the heart, lungs, and nervous system, for example, do function with less efficiency as the body grows older. Higher levels of stimulation often become necessary in order for older people to see, hear, taste, and smell as well as they did when they were younger (Woodruff & Birren 1975). These changes affect individuals' abilities to react to their environment and may lead to feelings of social isolation. The gradual slowing down in reaction time of the central nervous system may produce a sense of conflict and inadequacy as older people face a world of rapid change. In such situations, counselors can greatly assist preretirees and retirees by providing relevant information and suggesting ways to adapt to and compensate for biological changes.

According to Kimmel (1974), the body seems to be less able to resist disease as it grows older and over time disease itself may be a factor in aging. Chronic, long-term, or incurable diseases include arthritis and rheumatism, heart conditions, and high blood pressure and the most frequent causes of death are heart disease, cancer, and strokes. The possibility of disease prevention through good health care may be of signal importance to aging and to the greater enjoyment of retirement.

Continued ability to learn is important for older people (Atchley 1977). One research study suggests that some intellectual processes do not seem to change with age, while some decline and some improve (Nessebroade, Schaie & Baltes 1972, cited in Atchley 1977). Another study indicates that aging does not affect stored information but in some situations tends to slow down problem-solving ability (Reed & Reitan 1963, cited in Kimmel 1974). According to several studies, memory decline as an element of aging is more a matter of information retrieval than of acquisition (Johnson 1972; Thomas 1972; Waugh 1972; all cited in Kimmel 1974). In some cases, creativity, motivation, and emotional reactions seem to be reduced with aging, but restricted social and physical environments may be more potent influences than biological change. The range of individual differences in abilities to learn is tremendous and health and education are important factors to continued learning ability (Kimmel 1974).

Psychological Factors. Closely interrelated with biological factors are the psychological factors influencing reactions to and attitudes toward retirement. Of particular interest to counselors are the possibilities that the quality of adjustments to aging is closely related to personality characteristics developed over a lifetime and that age differences should be studied in terms of the influencing social factors as well as the biological factors (Atchley 1977). For example, the illness and death of loved ones combined with declining interactions with friends and relatives can lead to feelings of despair, isolation, and even physical discomfort.

As a significant transition point, retirement is likely to be a stimulus for a life review process in which individuals evaluate their contributions to their jobs, their friends, and families, and their own growth as successful human beings. Feelings of accomplishment and satisfaction can contribute to favorable attitudes toward the retirement period. On the other hand, feelings of frustration and failure may increase the problems of transition. The question, "Who am I?" is often involved. Depending on past experiences, responses to this question can strengthen a sense of personal identity and integrity or produce feelings of despondency and failure. The tendency toward introspection seems to be a logical consequence of the early retirement period (Kimmel 1974).

Several researchers have tried to identify those personality factors that influence successful aging. For example, according to Reichard, Livson, and Peterson (cited in Kimmel 1974), five personality types seem to be related to the quality of adjustment to retirement. Three are associated with satisfactory adjustment. The first, described as "mature," accepts the aging condition and finds enjoyment in activities and personal relationships. The second, labeled the "rocking chair" type, tends to be more passive and accepting of existing conditions. The third, called "armored," is active and deliberately avoids or suppresses feelings of anxiety over personal decline. Of those failing to adjust to advancing age, the "angry" persons compose the fourth type, who are bitter over past failures and blame others for what they are. Those in the fifth group are like the fourth, except that they blame themselves for their failures; they are the "self-haters."

Neugarten (1973) also discusses personality types in relation to successful aging and adaptation to retirement. It seems clear that in order to be of maximum assistance to retirees, counselors must gain information about past life styles and help retirees identify and consider alternative lifestyles.

Sociocultural Factors. Among the variety of factors influencing attitudes toward retirement is society's view of aging and retirement. Federal legislation still permits mandatory retirement, in the private employment sector, which by its very nature places a negative connotation on the meaning of retirement. Federal laws that have set ceilings on the earnings of Social Security recipients under 72 years of age have tended to limit opportunities for recipients to seek new work activities (Butler 1975). A youth-oriented society views retirement as undesirable and unpleasant, and the news and entertainment media tend to accent the negative aspects of aging. Fortunately, changes are under way whereby, over a period of time, retirement may be viewed in a more positive light.

Individuals with adequate retirement income tend to look on retirement favorably (Atchley 1976), as do those who seek more leisure time to devote to their own interests. In some job settings retirement may be seen as a normal element of employment and as a part of living to which people look forward. In addition, if associates on the job, in the neighborhood, or in social and professional organizations generally favor retirement, those eligible to retire are usually inclined to do so. On the other hand, if associates look down on retirees and refer to them in negative terms, retirement is likely to be avoided, if possible.

In a family situation, relationships between husband and wife are generally conditioned by the nature of their employment. The retirement of either or both refocuses attention on the nature of their employment and on the nature and quality of relationships in the home. If these relationships have been of poor quality, considerable strain on any readjustment efforts may be anticipated. In any event, both husband and wife can expect to rethink and revise their roles within the family unit.

Some specific sociocultural problems may arise for those approaching retirement. In the case of married couples, incompatibility that has been avoided or largely ignored for many years may become a dominant issue and may lead to divorce. For either spouse, but especially for the woman, divorce tends to isolate the individual from customary social activities and to attenuate social relationships in a society organized for couples.

A related problem is the difficulty, both imagined and real, for older people to establish new relationships with the opposite sex. The stereotype that older people no longer experience the sex drive is broken by evidence indicating that satisfying sexual activity extends into the seventies, eighties, and beyond (Masters & Johnson 1966, cited in Kimmel 1974). Marriage and family counselors have the opportunity to help older people, as well as their adult children, understand that continuing sexual expression is both normal and desirable.

Maintaining a sense of masculinity or femininity is also a significant issue related to retirement (Broderick 1975). Counselors should be aware of differences between males and females that seem to develop with age. Older men tend to relate to their environment in more cognitive ways, while older women appear to become more affective in their responses. Older women seem to react more aggressively, while older men move toward more affiliative and nurturant behaviors (Neugarten 1973). Sensitivity to the possibility of such differences enables counselors to better understand the attitudes and behaviors of older people and to react in more effective ways.

For the minority elderly, the problems associated with society's negative attitudes toward aging are compounded by the continuing difficulties brought about by racial prejudice. Added to these problems is the grinding impact of poverty. According to a 1971 report from the Senate Special Committee on Aging, the percentage of older Blacks below the poverty level is double that of older whites. In rural America, two-thirds of the older Black population live in poverty (U.S. Senate Special Committee on Aging 1971). For many minority elderly, and a sizable number of white elderly, retirement represents merely a continued struggle for existence.

RETIREMENT: PLANNING AND ADJUSTMENT

It is essential that older people view their retirement as a significant period in their life span. This period, like previous ones, requires adjustments to changing conditions and the development of a satisfying life style that includes activities consistent with long-established values. To be stressed is the fact that older people should continue to be productive as well as creative.

As already indicated, establishing a new identity ranks high among the challenges to be met during the retirement period. Others include compensating for possible reductions in income and for possible constraints on the accustomed range of physical activities. If older people are stimulated by the variety of opportunities in retirement, they are more likely to see retirement as a new life period. In terms of significant life periods, an older person's retiring from the job seems comparable to a younger person's leaving the family home. In each instance, the individual is leaving a familiar setting and moving out into the unknown. But there are differences, of course. Perhaps the greatest is that the young person views the future as infinite; the older person has discovered that it is not. Such a discovery may require the assistance of counselors who can help retirees find new life goals and new areas for meaningful activity.

Financial Planning. Understanding the facts of retirement income and planning for a life style within that income are requirements for a satisfactory adjustment to retirement. Obviously, some financial planning should occur years before actual retirement for those who can manage to build up a savings account, invest in property, stocks, or bonds, and/or maintain an insurance program.

Within 10 years of retirement, individuals should prepare a retirement budget as a means for estimating income and the resulting limits established for retirement living. According to the U.S. Department of Labor (Kimberly-Clark Corporation, undated) the average retired couple can anticipate this kind of budget:

Housing	33.6%
Food & beverage	27.7%
Goods & services	13.6%
Clothing	8.9%
Transportation	8.9%
Medical care	7.3%

Although inflationary economic conditions make planning more difficult, when prepared soon enough such a budget can encourage changes in current living habits to make possible a retirement budget that seems to approximate minimum preferences. Some help is available for those who retire after age 65, with special income tax schedules for retired people that offset some losses in total income. But care and planning should begin early to reduce overall living costs. The Kimberly-Clark Preretirement Planning Manual (undated) suggests, for example, such ordinary practices as buying when and where there are sales, buying house brands, buying middle-priced items, and buying with cash to avoid finance charges.

Physical and Mental Health Planning. Planning for physical and mental well-being is really a lifelong requirement that should begin, ideally, at an early age and not near the time of retirement. Although Americans are generally sensitive to the importance of medical insurance against illness — which is indeed important — they tend to ignore the significance of preventing illness. An increasing awareness of maintaining good health is indicated by the growing participation of people of all ages in physical exercise, such as jogging, and in a variety of relaxation activities, such as yoga.

An interesting and refreshing approach to physical health is taken by Ardell in his book High Level Wellness (1977). He argues that "wellness is a way of life which you design to enjoy the highest level of health and well-being possible during the years you have in this life" (p. 93). He describes five dimensions of wellness. "Self-responsibility" is the key to high level wellness because it provides the motivation to avoid such high risk behavior as smoking and drinking. "Nutritional awareness" emphasizes wise selection of food products and sensible patterns of diet. "Stress management" requires the personal development of skills to recover and maintain mind and body relaxation during times of stress. "Physical fitness" means adequate conditioning so that individuals feel good and gain pleasure from the sensation of muscle tone. "Environmental sensitivity" refers to the ways in which individuals shape and react to their physical, social, and personal environments through their choices of living space, work, friends, and life style.

Life-Style Planning. Planning for a retirement life style involves at least three elements: an evaluation and possible reordering of personal goals, some substitution for the job from which the individual is retiring, and reasonable continuity in living conditions (Atchley 1977). Life-style planning really represents the framework within which plans for financial self-sufficiency, continued mental and physical health activities, continued work, and personal growth are organized.

If work has been an essential part of living, work of some kind might be considered in life-style planning. Other essential elements include meaningful relationships with others and satisfying uses of leisure time. An important personal quality in retirement is flexibility, which facilitates adjustment to change. Some retirees find it desirable to reduce the number of roles they have had while others wish to discover other roles. Still others, who have maintained low activity levels satisfactorily, may make few changes as they move into retirement.

The development of personal potential in retirement is, obviously, a highly individual matter, dependent in part on personality characteristics and personal solutions to identity crises. Each person discovers his/her own life style and this process must be both respected and encouraged by the counselor. In this process, the counselor can help the retiree review personal potentials and consider environments most favorable for developing them.

PRERETIREMENT PROGRAMS

The impact of retirement on life style, sense of personal identity, and attitude toward living can be so great that thoughtful preparation could be assumed to be a foregone conclusion. According to Atchley (1977), planning for retirement seems to improve adjustment. Various other studies of retirement imply that planning is indeed important. Yet adequate individual preparation for retirement seems to be rare and formal programs are few and sometimes cursory.

Attitudes toward preretirement planning vary widely because, as previously discussed, individuals approach retirement so differently. Those in the middle income bracket appear to be most interested in planning and willingly participate in preretirement programs (Atchley 1977). Those with higher income, higher job status, and more education are often reluctant to consider retirement and therefore tend to avoid information about it. Those with lower income, less education, and more mechanized types of work seem to look forward to retirement and to view it as something they can do little about (Atchley 1976). Regretably, then, the largest number of workers and those who might benefit most from preretirement planning are least likely to get involved. This situation suggests the importance of tailoring preretirement planning to the needs and attitudes of specific groups of workers and emphasizing individual attention to these needs and attitudes.

Also significant may be the length of time during which preretirement planning takes place. Atchley (1977) suggests a long-term incremental approach, initiating an orientation to retirement during the public school years. For the mid-30 to mid-40 age group, programs might be presented on financial planning and leisure time. Just before retirement, special programs could feature such topics as health, housing, legal matters, and continued opportunities for work (Atchley 1977). However preretirement planning is accomplished, the point is that it should begin at least 10 to 15 years before retirement.

A crucial first purpose of preretirement programs is to help individuals explore their own feelings and form positive attitudes about retirement. Other important purposes are to provide information, assist in evaluating this information in terms of particular circumstances, urge consideration of all possible options, and encourage realistic decisions regarding actions to take in preparing for retirement. Two major problems should be anticipated. First, those attending the program may not really be ready to accept information about retirement and, second, they may not have the skills necessary to make important decisions.

Given these problems, counselors must determine the potential participants' readiness to participate and include initial group activities that will both increase the receptivity to information and provide some experience in decision making. Advance questionnaires can be used as a means of gathering information. Preliminary small group exercises may produce the stimulation and provide a simulated experience for improved acceptance of and reaction to the information sessions that follow. Additional small group activities can then help participants see where they are in the preretirement process and give counselors useful clues regarding the effectiveness of the program and those who might benefit from individual counseling sessions.

Successful preretirement programs require trained counselors and a professional staff who possess the knowledge and skills to produce the desired result. The staff should have basic knowledge of the characteristics of older people, human behavior, and essential elements in preretirement and retirement planning. Of vital importance are skills involved in group processes and in providing appropriate experiential program components. Information takes on meaning for individuals only as it becomes a part of their experience.

Psychological adjustments before and during retirement may be aided by a confidant, a person to whom the older individual can talk about problems and about him/herself. Intimacy and stability over time are important features of the confidant role. Confidants are more common for women than men, married persons than widows, and widows than single persons. A spouse, child, or friend seems to be most frequently selected as a confidant (Kimmel 1974).

Kimmel has reported research by Lowenthal and Haven to the effect that confidants tend to mitigate the adverse effects of role loss and reduced associations with others (Kimmel 1974). The confidant's support in bolstering morale when the problems are physiological does not seem to be as effective. In any event, the loss of a confidant can be even more devastating than the loss of other social relationships.

The confidant's importance to the older person suggests a readiness for help from a counselor. At the same time, the significance of stability in the confidant's role poses a problem that the counselor must take into consideration, namely, the time commitment involved.

Atchley (1976) comments that, "A prime issue in formulating programs is whether the emphasis should be on crisis prevention (through counseling) or on providing information and stimulating people to plan for retirement" (p. 158). He concludes that providing information and encouraging people to plan are more realistic goals than counseling, in view of available resources and limited time. Such a conclusion raises two problems: the definition of counseling and the dubious value of presenting information and encouraging planning if participants are not ready to use the information or are unaccustomed to independent planning.

The fact that preparation for retirement is a highly individual activity suggests the importance of individual counseling at various stages of the preretirement process. At the same time, group counseling can be particularly effective in favorably influencing attitudes toward retirement, providing feedback and support, and motivating for action.

Support and Location. Most preretirement programs in existence are supported by companies with private pension plans and by government agencies. Some of these programs do little more than review retirement benefits and time options; others are more extensive. The programs are usually held in company or agency offices.

Broader support seems essential to the development and expansion of retirement preparation programs that will reach those who need them and that will in the process establish such preparation as a routine part of living. Business, industry, and employee unions, for example, might logically include preretirement education as a fringe benefit, with a trained counselor or educator employed for administration. Religious organizations could logically offer such programs, as might community centers, social and civic groups, and a variety of municipal, state, and federal agencies. Educational institutions should also be involved in providing programs, program sites, and training for program staff.

Financial support for preretirement programs seems a reasonable addition to the list of benefits already provided for employees by many organizations. Such support initially depends on the awareness, understanding, and appreciation of the importance to both individuals and society of a satisfactory transition to retirement.

Program Topics. For the more comprehensive programs, topics customarily include financial planning, legal matters such as preparation of wills, health, housing, nutrition, work, and leisure. At least one state model includes a discussion of the "declining golden years" — an approach likely to dismay even the most optimistic people.

Although generalities about financial planning and legal matters may prove superficially useful, assistance on an individual counseling basis may be essential for a number of older people, in view of the importance of confidentiality and trust. Realistic planning of retirement finances should include the preparation of income and expense budgets. Discussions about health should stress the fact that continued activity makes possible the continued capacity for activity.

The format for topic presentation may vary from formal courses of instruction to concentrated workshops, monthly seminars or periodic programs on radio or television. In all cases, an essential objective is to raise the level of consciousness about retirement, its requirements, and opportunities.

LEISURE AND PERSONAL GROWTH IN RETIREMENT

Using the concept of leisure as an important avenue of personal growth in retirement is highly desirable but sometimes difficult. The problem lies in the often negative overtones of the word "leisure," which is taken to mean the opposite of work, hence, in a work-oriented society, idleness, nonproductiveness and perhaps even sinfulness.

What Is Leisure?

Kelly (quoted in Kimmel 1974) defines leisure in terms of the amount of choice a person has in performing an activity and the relationship of the activity to the person's job. His model identifies three types of leisure: "unconditional leisure," which is freely chosen and not related at all to one's job; (2) "coordinated leisure," which is freely chosen but has some relationship to one's job, and (3) " complimentary leisure," which, strictly speaking, is not freely chosen but is not directly related to one's job. The key concepts are freedom of choice and relationship to the job.

Neulinger (1976) suggests a positive view of leisure in terms of its conditions and functions. Such conditions include "integrity of purpose, liberty to review goals, objectivity, equality in fellowship, common command of skills, and growth" (p. 8). The Greeks emphasized contemplation and activity for its own sake. The Romans viewed leisure in terms of rest and recreation. The Chinese combined these ideas in the proverb, "To be for one day entirely at leisure is to be for one day immortal" (Neulinger 1976).

Perhaps counselors will find it most helpful to think of leisure in terms of, first, an attitude of mind and, second, what it can do for an individual rather than what it is. An important point is that leisure must be conceptualized in much the same way as work. Like work, leisure can be the means for developing feelings of self-worth, social status, and one's individual potential. Leisure too can lead to self-discovery and a better quality of life. Leisure differs from work in that it has no external constraints on the use of time and its direction is basically controlled by the individual.

Counselors have two initial responsibilities in working with older people in the area of leisure: first, to understand leisure as a positive and unique activity with values in and of itself and, second, to educate older people in the meaning and use of leisure time and in the diversity of the options for leisure. In work-oriented America, neither responsibility can be lightly undertaken, especially when people over 45 years of age who may regard leisure in dubious terms (counselors as well as counselees!) are involved.

The Importance of Leisure

Technology and greater worker productivity are resulting in more time available that is non-job-related. Prospects for the near future include shorter work weeks, longer vacations, more time for retraining and education, and earlier retirement. What will people do with this free time? Will they watch television more often, sleep longer, drink more beer, or will they take more trips, play more games, indulge more hobbies? Will they seek more education and participate in more volunteer activities? For individuals trained to live and work by the clock, uncommitted time can trigger a series of compulsive activities intended only as fillers. Coping with free time is one thing; using it for self-development is another. Changing stereotypic attitudes toward leisure are likely to be essential to the mental health of people of all ages.

On a long-term basis, changes in attitudes toward leisure must begin in the home with the family, where the attitudes are first developed. The educational system has a particular obligation to include in its objectives enjoyment of living as well as preparation for work and to provide learning opportunities in the creative uses of leisure. When individuals pass middle age the chances are that their attitudes toward leisure and their leisure activity patterns are well established. For this reason, especially if they have limited their leisure activity, encouraging older people to participate in leisure activities may be a major problem.

The problem must be faced. In retirement, older people have the alternatives of doing nothing, which can be fatal, finding a substitute for work, or developing leisure activities, which seems to offer the most productive possibilities. Leisure activities, in fact, can be built on skills gained on the job; their appropriateness can be reinforced if retired friends follow the same course of action. As a consequence, leisure can give continuity to individual identity in retirement. This possibility is enhanced when people have maintained multiple roles during their years on the job.

Counselors must be keenly aware that encouraging productive uses of leisure may be vital to preventing the maladaptive reactions of some older people when they find themselves with nothing to do and time on their hands. Alcoholism in later life is a problem that seems to grow out of such experiences as grief and loneliness (Butler 1975). The excessive use of drugs may often result from continued use of medications originally prescribed by physicians or purchased over the counter on the advice of friends. Suicides are most common among older white males; 25 percent of reported suicides occur in the population over 65 years of age (Butler 1975). In recognizing the variety of causes for these behaviors, counselors should be sensitive to the symptoms of possible problems and should help the concerned older person who wants to find acceptable solutions or substitutions for detrimental behavior.

Variety of Leisure Activities

The objectives of leisure fall along a continuum of activity ranging from relaxation to diversion, development, creativity, and sensual transcendence (Gordon, Gaites & Scott, cited in Binstock & Shanas 1976); those of more advanced age tend to choose quieter, less intense activities. Social environment, limited funds, availability of transportation, and physical condition are among the factors involved in choice. Socioeconomic background also seems to be associated with choice: those in the upper middle class tend to select such activities as sports, reading, and gardening; those in the middle class favor crafts, reading, and television; those in the lower class prefer visiting friends and relatives (Atchley 1977).

Overs, Taylor, and Adkins (1971) have developed an Avocational Activities Inventory using the Dictionary of Occupational Titles as their model. These activities are organized into nine major categories: games, sports, nature activities, collection activities, craft activities, art and music activities, educational, entertainment, and cultural activities, volunteer activities, and organizational activities. This revised list omits social relationships. Travel and religious activities are included under educational, entertainment, and cultural activities. In developing this inventory, the authors endeavored to list the categories in order, from the most concrete to the most abstract.

The Avocational Activities Inventory represents a useful tool for counselors who are helping older people select leisure activities. Finding constructive and satisfying uses of leisure time may prove difficult for some people for several reasons, such as limited information about activities and their availability in the community, negative views of their own ability to participate, or their inability to determine personal interests. This inventory can be helpful both in providing information and in contributing to the decision-making process. (Overs, Taylor, & Adkins 1971).

Jobs. Some retirees seek other jobs, more often on a part-time basis (Butler 1975). In a few larger cities, agencies specialize in placing older people in full-time as well as part-time jobs. Employers are reported to be very favorably impressed, noting such qualities as productivity, dependability, and steadiness (Butler 1975; Sheppard, cited in Binstock & Shanas 1976).

The Harris report (1975) indicates that more people in the 65 to 69 age group than in the group age 70 and above are employed. Of the 65 to 69 group, 4 percent are employed full time, 14 percent part time. These percentages drop to 3 percent full time and 8 percent part time for those in the 70 to 79 age group.

Retraining for jobs, either part time or full time, in new areas of work represents an alternative possibility. For example, those who retire from military service may use their active duty experiences in obtaining civilian employment or may enter educational programs leading to completely different types of jobs. Retirement may provide some workers with the opportunity to transfer to a job quite different from the one they held before, perhaps a job the individual had long wanted to try but could not for a number of reasons.

The federal government has taken some action, although in only a very modest way, to make minimum wage employment for some older people available. The Community Action Program includes the Foster Grandparents Program, which employs people over 60, who are below the poverty level, to work with neglected and deprived children in or out of institutions. The U.S. Department of Labor has responsibilities for Green Thumb, Green Light, senior aides, and senior community service aides. Green Thumb employs men 55 years of age or older in outdoor gardening, maintenance, and landscaping work. Green Light enables women to work in libraries, schools, and day-care centers, and to assist the handicapped and shut-ins. The senior aide programs support jobs in such areas as home repair, child care, and health assistance (Butler 1975). The Comprehensive Senior Employment Act, Title IX of the Older Americans Act of 1965, channels funds for the employment of poverty-level elderly into a variety of jobs.

Volunteer Service Activities. Of those U.S. citizens who are 65 years of age or older, 22 percent report active participation in some type of volunteer work (Harris et al. 1975). This percentage amounted to 4.5 million persons in 1974, with an additional 10 percent or 2.1 million, indicating their willingness to serve as volunteers. The percentage of those involved declines with age, but the number participating who are 80 years of age or older is notable. Older people with some college education and above poverty-level incomes are most likely to be volunteers.

The variety of service activities is considerable, with the greater number of older people involved in health and mental health, transportation, civic affairs, psychological and social support services, giveaway programs (making available such items as food and clothing), and family-, youth-, and child-oriented services (Harris et al. 1975).

Specific volunteer programs funded by the federal government include the Retired Senior Volunteer Program (RSVP), which recruits older people, provides training, transportation, and meals, and arranges for part-time placement in a wide variety of settings. The Service Corps of Retired Executives (SCORE) makes retired executives who serve as consultants available to small business firms. There are other programs of value to both those who serve and those who are served, for example, the Telephone Reassurance Program, Friendly Visitors Program, Meals on Wheels Program, and Bereavement Counseling Program.

There is general agreement among older people that volunteer work has real advantages and personal rewards for the participants. At the same time, some older people also feel that if their work has real value they should be paid for it. They do not object to carrying their share of volunteer service, but self-respect and financial needs motivate them to expect adequate compensation for work performed.

Lifelong Learning. Because of technological advances, fewer people will be needed to perform the work necessary to meet society's subsistence requirements. More people will be available to provide more services for more people. Because there will be fewer jobs, more part-time jobs may be created, more leisure or independent time will be available, and more use will be made of educational opportunities. Butler (1975) raises these questions:

> ... might it not be possible to consider arranging our fundamental work-and-money patterns and eliminate retirement as it is currently practiced? Why not redistribute education, work, and leisure throughout the life cycle instead of concentrating those activities into three distinct periods: early life, middle life, and old age? (p. 102)

The American educational system has the potential for contributing substantially to new attitudes and new approaches to work, leisure, and learning on a continuing basis. Modest beginnings are being made, especially at some of the community colleges where special courses for older people are being offered. At some institutions tuition is waived for those over 60 and a variety of learning activities is developed cooperatively with organizations of retirees. Some federally funded projects, such as part of the Action Program, are bringing older people into public school classrooms. Such projects result in part-time volunteer work, association with children, and opportunities for new learning and new vistas for enjoying life for the older people involved. For the children, one result often is a pleasant association with and new respect for older people.

Such programs are only a beginning. Yet to be organized on a full-scale basis is comprehensive educational instruction that will focus on preretirement preparation, retirement activities, opportunities for being more fully oneself, and training for part-time jobs and creative uses of leisure time. As one educator has said, "If we can provide Medicare for better health, why can't we provide 'Educare' for better living?"

Development of such educational programs will require at least two fundamental changes in our educational institutions. First, the concept of lifelong learning must be more widely accepted so that educational programs will no longer concentrate only on the 6 to 24-year-old age groups. Second, policies, procedures, and subject matter must be adapted to accommodate the living patterns and needs of the 25 to 85-year-old age groups. Changes in the U.S. population toward more people in the older age groups are likely to stimulate such changes, for economic reasons if no other.

For counselors and educators, one of the current problems to be faced is that as many as 15 percent of Americans over 65 are functionally illiterate; on the average, the remainder have a minimal education. As of 1975, the average person over 65 living in an urban area had had eight years of schooling; less, if s/he lived in a rural area (Butler 1975). Special techniques will obviously be required to help people in these categories continue to learn.

Older people approaching or into retirement should have the advantages of appropriate training that will enable them to continue their personal growth, much as training is provided for younger people who are maturing and preparing to enter the work force. For older as for younger people certain critical life issues must be successfully met. The first is personal identity: "Who am I?" "Am I needed by someone, somewhere?" The second is sexual intimacy. The stereotype that the need for sexual relationships die with advancing age must be overcome. A third issue is maintaining a sense of personal responsibility as a mature individual. Retirement does not mean that one is no longer capable of assuming or continuing responsibility for one's own life, contrary to the stereotype of aging too often accepted by older people themselves and especially by their offspring and society in general.

Additional educational opportunities cover a wide range of topic areas, from learning more about oneself to understanding more about one's world. The objectives may include a career or a formal degree; they might also focus on learning and personal development. Special instructional programs should concentrate on preparation for retirement, postretirement living, personal growth for life satisfaction, and specific training for social service activities, either paid or volunteer. Perhaps the greatest error committed by those responsible for developing educational programs for older people is to assume that bingo games and handcrafts fulfill the range of their educational, recreational and leisure needs.

Personal Development. A healthier, more realistic approach to retirement and aging is likely to be found through a conception of life and living as a continuing developmental process. An appreciation of developmental change should enable older people to gain greater insight into their physical, mental, and spiritual life and to cope more effectively thereby.

The extent to which physical dexterity and agility continues into later life stages varies greatly among people. To recognize at the appropriate point the fact of diminishing physical capacities and to modify one's activities is to adapt realistically to physical change. Continuing physical activity commensurate with one's abilities should enable one to maintain a sense of physical fitness and well-being.

How individuals continue to exercise their mental and emotional capabilities will also vary greatly and will depend on previous habits as well as present stimulation. Indications are that continued mental stimulation and active response have much to do with continued physical well-being. Reading, listening to music, observing nature and art, group discussion, lectures, social interaction, and travel — all contribute to updating and enriching the daily lives of older, as well as younger, people. Reminiscing about past events can also be useful if, in the process, individuals find new meaning for their lives (Butler 1975).

As older people reflect on their past, they are likely to question the meaning and value of their existence. In this introspective process, many will find personal security and comfort in their religious experiences, past and present. Others may develop interests in such activities as meditation. Spiritual life can be a source of support as the individual comes to appreciate the more reflective role of the elder, who is free of the pressures and time constraints of the marketplace.

Counseling for Leisure

Once counselors understand what leisure is and what it can do they should be alert to the variety of related client needs. One major need may be for information. Another could be the client's need for the clarification of leisure preferences and leisure/work relationships and values. A third might be to develop skills for leisure activities. Whatever the need, counselors should be aware of their abilities to be of assistance to older people who might need help in using leisure time as a significant means for personal development in retirement.

HOUSING

Where and how older people live can be the single most important factor in their lives after retirement. Simply stated, the physical and social environment exerts a major impact on the attitudes and sense of well-being of men and women, both younger and older. These environments include physical structures, transportation, shopping, medical services, and opportunities for social relationships. Housing units should encourage individual development and the realization of a fuller life.

A number of considerations are involved in the decision of where to live in retirement. To best assist retirees who are attempting to reach important decisions about where to live, counselors should be aware that these considerations range from such personal issues as independence and preferred life style to physical matters such as environments appropriate to the changing conditions of physical and mental health. Counselors should have both sensitivity to the retiree's feelings and knowledge of realistic housing possibilities.

Extending independence in daily living is a high priority. Some circumstances of retirement, particularly reductions in financial resources and job responsibility, can tend to undermine the feeling of independence, which maintains self-esteem and a belief in self. The fact that fewer than 10 percent of those over 65 express a preference to live with children or relatives suggests the importance they place on independent living (Shanas, quoted in Atchley 1977). Independence is certainly to be encouraged whenever possible.

Carp (1974) has listed a number of situational resources that seem to be related to the elderly's capability for living on their own. They include adequate income, living with a spouse rather than alone, amount of education, favorable self-concept, reasonable health, personal identification as "middle-aged" rather than "old," and a number of friends (Carp 1974). Carp specifically used these and other resources as predictors of older people's adaptation to a new housing environment. They can also serve as an informal checklist for consideration when decisions about place of residence are made.

Providing access to family, friends, and services should be carefully considered. Independent living ensures privacy and a reasonable measure of personal control over one's environment. At the same time, continuity with the past is a basis for enjoying the present. Being able to exchange visits with family members and friends is a means for maintaining a sense of continuity and identity. Also desirable is reasonable proximity to such services as drug stores, grocery stores, and churches, since walking has the advantages of providing physical exercise and eliminating the cost of transportation.

Supporting a desired life style is one more consideration in the decision about where to live in retirement. If older people want to be out of doors, appropriate ground space around the house is essential. Interior spaces should be analyzed in terms of planned activities. For example, a room with maximum natural lighting is necessary for such indoor activities as painting and sewing. A kitchen should minimize stooping, kneeling, or using a ladder to get out of reach items. Such procedures as adding a 12-inch platform under a refrigerator, installing a wall-recessed oven, and obtaining a stove with front controls only will increase the pleasure of working in the kitchen and will reduce the chances for personal injury.

Reducing responsibilities for upkeep is worth careful consideration. For many people one of the pleasures of having a home of their own is the opportunity for taking care of minor (and sometimes major) repairs; replacing a screen, waxing a floor, painting a room, or mending a chair all provide tangible evidence of accomplishment. But in planning their retirement residence, some people may want to seek facilities that require little or, better still no maintenance. In such circumstances, the necessity to alter interior finishes and equipment should be minimal. In planning the purchase or renovation of living accommodations, older people are well advised to see that these will need little maintenance.

Security is of increasing importance in the face of mounting crime rates in all living areas, from inner cities to residential suburbs to rural settings. Older people may be special targets for assault and robbery because of the generally held view that they are less able to defend themselves and strike back. Whatever the situation, attention should be given, first, to the neighborhood and the proximity of those who can and will respond to calls for help and, second, to adequate safety features of the housing unit itself. Such features include exterior lighting, adequate locks provided for doors and windows, and conveniently located alarm systems for use in calling for help.

Physical and mental health, in terms of both present conditions and future possibilities, should be carefully evaluated by retirees when they consider where they will live. According to Havighurst, (cited in Binstock & Shanas 1976), 85 percent of those over 65 and not institutionalized have one or more chronic ailments. It is important, therefore, for older people to determine their physical condition and the steps they should take either to correct deficiencies or to maintain a satisfactory state of physical health. Steps to climb and accessible recreational facilities are only two items in this area to consider.

Maintaining mental health usually includes opportunities for human association as well as the condition and appearance of the physical environment — all are matters involving retirement housing. Of particular interest is Rosow's 1967 study (cited in Binstock & Shanas 1976) which indicated that socialization within housing projects appears to improve when larger numbers of older people live in proximity. The advantages of such a situation seem to be even greater for those of a lower socioeconomic level.

Transportation between the housing unit and essential services, including activity centers, is an element of vital concern for several reasons. First, personal or public transportation enables older people to maintain their sense of independence. Second, transportation makes association with others and participation in activities feasible. Third, transportation permits the continuation of customary activities such as shopping, medical appointments, and attending church and a variety of cultural-recreational activities. If reasonably convenient transportation is available, the transition to retirement living is facilitated. If public transportation is to be used now or in the future the housing unit should be in easy walking distance of established transportation routes.

Living costs for remaining in present housing or for moving represent the key element that controls the final decision about retirement housing and directly influences all the other considerations discussed in this section. Financial counseling is usually essential at this point as a rational means of analyzing relative costs and determining what course of action is best from both a short-range and long-range point of view. Although requirements for living may diminish after retirement, inflation will substantially reduce purchasing power. Part-time employment may prove to be part of the answer to the critical problem of living costs. Also significant may be the decision regarding retirement housing, which must help to hold costs in line.

Housing Alternatives

The latest available information indicates that about 90 percent of all older Americans live in their own homes, which are often free of mortgage obligations (Atchley 1977). Many of these homes, however, are too large and expensive to maintain, with property taxes and utility costs increasing. Many are in need of extensive repairs and are located in deteriorating neighborhoods. In the case of the rural elderly, about 20 percent of their homes reportedly do not have complete plumbing. Many older persons may have no realistic alternatives to their present housing; sizable numbers may have alternatives, even though they do not believe it. Many want to make a change, or should, but are unsure of the best course of action for them.

Counselors can fulfill a special role by helping to facilitate the process of making a decision about where to live. This process includes helping older people clarify their needs and desires for their housing, determining types of supportive environments and locating a particular housing environment and housing unit that best satisfy needs and desires. There are a number of options.

Remaining in the family home represents a first alternative, elected by the great majority of older persons. The advantages often include personal independence, the security of continuity in remaining in familiar surroundings, no costs for rent, and no requirements for adjustment to the environment. On the other hand, there may be disadvantages such as high taxes, high utilities, and high maintenance, excessive living space, and memories that may become oppressive to mental health. In the surrounding neighborhood, crime may have increased, personal security may be difficult to maintain, and the older person has become isolated from relatives, friends who have moved away, and services.

Many of the same factors would apply to rented housing where individuals have continued to live for a long time. Survey information indicates that considerable numbers of older people live in rental apartments in older sections of cities where rates are low. Some live in rented rooms and boardinghouses.

Moving into rental units is a frequent alternative for those who desire less living space, less responsibility for upkeep of the unit or yard, and more opportunities for association with others of similar age and interests. The units might be located in an apartment building or condominium, a retirement village or hotel, a mobile home village, or a public housing project particularly designed for older people.

A condominium, mobile home, or retirement hotel will ordinarily require an initial cash outlay which may be large. The monthly rental, which as a general rule should not exceed 25 percent of income, should also be carefully evaluated. For those who meet the maximum income requirements, public housing is often an excellent alternative because of the facilities and especially the opportunities for socialization. A federal rent subsidy program, Section VIII of the Housing Act of 1937 as amended, enables older people to live in a variety of privately owned rental units, with the dollar difference between percentage of income and actual rental rate funded through this program.

Moving to a different geographical area after retirement is an alternative adopted by many older people, most of whom are migrating to the Sun Belt, which stretches across the southern United States from southern California through parts of Texas, Arizona, and New Mexico to Georgia and Florida. Motivations for moving include warmer climates and varied recreational opportunities, climates that improve physical health, and the encouragement of friends who are moving to the Sun Belt.

Disadvantages can include the break with familiar environments and family members and an adjustment to new life styles. Unresolved problems in establishing goals for retired living may produce dissatisfaction with the new locations that has little to do with the location itself. Testing a new location for as long as a month and meeting and talking with older people who live there is a highly preferred way to reach the decision to make a permanent move.

Choosing to live with children or relatives is an alternative selected by few older people. The basic problem, of course, is the possibility that the elders in the household will develop feelings of dependency or that there will be clashes of personalities and/or generations. Many times, however, relationships may be so congenial that all parties are willing to compromise points of view with minimal difficulty. In some cases, inadequate income may leave the older person with no alternatives. In this event, individual and group counseling may prove useful for the development of mutually satisfying relationships in the extended family unit.

Moving to adult congregate living facilities is often viewed as one of the least desirable alternatives. These facilities are intended for those individuals who may require assistance in their daily activities as a consequence of declining physical or mental health. Often, use of such facilities would not be necessary if adequate supports existed within the community (e.g., adult day-care programs and Title VII nutrition programs). Because these facilities provide opportunities for association with others of the same age, they can play a useful role in countering feelings of loneliness and isolation; however, interaction is sometimes minimal.

Many view moving to a skilled nursing facility, or nursing home, as the last alternative. Nursing homes are for those who may not be capable of living independently. People residing in these facilities may eventually require a great deal of personal care, assistance in eating, dressing, and walking. Although the literature indicates that we currently overinstitutionalize and that many people in nursing homes could be better served in other environments, these facilities are a necessary component of the long-term care system. They provide the 24-hour care services that may be required by the small population (less than 5 percent) who are severely confused or disabled.

Tobin and Lieberman's research suggests that older people apply to nursing homes for three reasons: physical deterioration, inability or unwillingness of family or friends to provide the necessary care, or "the inability of the current system of services to assure independent living" (Tobin & Lieberman 1976, p. 121). Reaching the decision to apply to a nursing home sometimes produces feelings of rejection, isolation, and abandonment.

Since the decision to apply usually involves family members, feelings of separation and loss are heightened. Such feelings may be reinforced by the family members who fail to visit the nursing home patient for any one of several reasons, including a sense of guilt. The counselor frequently works to bring together the patient and the family and, in the process, to reassure the patient that someone really does care for him/her.

Obvious reasons for negative reactions to nursing homes are loss of independence, adverse publicity about deplorable conditions in some nursing homes, and the realization that large numbers of nursing home patients die. According to Butler (1975), 85 percent of those entering nursing homes die there: one third within the first year of admission, one third within three years, and one third after three years.

In recent years the movement in the field of long-term care has been toward alternatives to institutionalization. At least some nursing homes operate on the assumption that the condition of many of their patients can be improved to the point that they can return for varying periods of time to their homes or to intermediate care facilities. This point of view, plus specific programs and personnel to help move patients toward better health, should improve the nursing home image in the eyes of older people. An essential factor in bringing about such an improvement is management policy that emphasizes the use of trained personnel in key positions, continuing inservice training for all staff, and a positive, caring attitude toward patients.

Reaching a Decision

Carp (1976) has suggested that any decisions for change from one housing location to another, particularly when alternatives are limited, be preceded by careful discussion and advance preparation on the part of all concerned, especially the older people involved. In summary, her points include the following:

1. Emphasize the desirability of the new accommodations.
2. Introduce the person to the new neighbors.
3. Involve the older person.
4. Follow the counseling model, not the selection and assignment model of industry.
5. Eliminate or reduce the feeling of irrevocability about the move.
6. Avoid undue delay in arranging to make a change.
7. Avoid premature moves.

These points are based on the conclusion that during the course of the aging process changes in living environments will be needed by many people. Consequently, communities should provide a variety of housing accommodations to meet the needs of the different stages of aging, from independent housing to congregate housing to intermediate care facilities to nursing homes to extended care facilities (Carp 1966).

Implications for Counselors

Certainly one of the significant developments in counseling in the seventies has been the realization that older people are as worthy of special assistance and as capable of growth as younger people or those in middle age. Such special assistance for older people, however, leads to a number of new requirements for counselors in the form of new areas of knowledge and new applications of counseling techniques in new settings and under a wide variety of conditions. Some of the implications for counselors, growing out of individual needs in retirement and the increasing numbers of retirees who are living much longer than their predecessors, are discussed here.

Awareness of Attitudes. One of the first implications of any study of retirement is that both counselors and clients must clarify their own attitudes toward aging and issues related to retiring from full-time employment. Counselors can never be fully effective in this area if their attitudes toward aging, retirement, and leisure are essentially negative. Clients are unlikely to change their behavior appreciably unless their attitudes toward aging, retirement, and leisure are positive.

Recognizing and changing attitudes is no easy task, but greater awareness of the sources of behavior that reflect changing attitudes represents a basic step. Such awareness in counselors and clients can be developed by group work and group exercises designed to raise the levels of awareness concerning aging, retirement, and leisure.

Developing More Knowledge. Areas in which counselors generally need to gain more knowledge include identification of issues surrounding retirement; financial, biological, psychological, and social-cultural factors that have major impact on individuals approaching or in retirement; socioeconomic differences in reactions to retirement; preparation of retirement budgets; understanding leisure and its potential; job opportunities for part-time work; opportunities for volunteer work; opportunities and alternatives in housing arrangements.

Since individuals of all ages need to expand their information about aging and retirement, special learning modules can be developed for classes in public schools, individual growth courses in college can be enlarged to include the concept of development throughout the life cycle, and special information programs can be arranged for meetings of civic groups and employees in business, industry, and government. One role for counselors in this general information effort can be to raise an awareness of the need for such programs in those who can establish policy and take action.

Exploring Developmental Tasks. Discussions about developmental tasks have usually focused on the early life stages: childhood, adolescence, and young adulthood. Counselors working with older persons must study in more detail the essential developmental tasks for those in at least four older age groups: 45 to 55, 56 to 65, 66 to 75, and 76 and older. Because the available information is limited, exploratory studies and research projects are greatly needed.

For those in these age groups, more information about significant developmental tasks should prove most helpful in assisting them to explore their existing behavior patterns in terms of tasks, the accomplishment of which might facilitate both intellectual and emotional growth. The interesting possibility exists that aging and retirement may result in a regression from the level the individual has reached in his/her satisfaction of needs. In this event, some tasks that have already been accomplished at earlier ages may have to be undertaken again. For example, even though the older person has satisfied the need for ego integrity, retirement and its circumstances may force him/her to reestablish identity, a task presumably accomplished during late adolescence or young adulthood.

Informal group work, individual counseling, and group counseling are possible steps to be taken by the counselor in determining where the client is in terms of task achievement and assisting the client in selecting appropriate courses of action that should lead to accomplishing certain relevant tasks. One approach to informal group work is for the counselor to prepare, perhaps with client assistance, a list of possible life goals to be achieved within a particular time. Such a list could then be the subject for informal group discussion.

Reviewing Value Systems. Closely related to exploring developmental tasks is encouraging older people to review their own systems. Theoretically, if the older person's values do not support the tasks important to his/her growth during a particular life period, the tasks will not be attempted successfully and the person will not experience personal growth. In order to be of assistance in this area, counselors may consider values clarification exercises that will help clients clarify their values and decide on some priorities for themselves. The results should enable clients to move toward their life objectives with a greater sense of purpose and greater potential for success.

Clarifying Counselor Objectives and Roles. In working with older people, counselors should be aware of how they can help those concerned with preretirement and retirement. The following is a partial list:

1. Training individuals in the decision-making process, particularly for those whose jobs have not provided adequate experience in decision making.

2. Helping individuals initiate and follow through on preretirement planning, keeping in mind the range of differences among older people and tailoring planning to individual abilities, needs, resources, interests, and readiness for retirement.

3. Helping individuals develop their own identity, life style, and social status in retirement.

4. Alerting individuals to new opportunities in leisure, exploring their own preferences with them, identifying sources of information, and helping them develop appropriate skills for leisure activities.

5. Training individuals in developing new person-to-person relationships in new living and leisure environments.

6. Assisting in the preparation of retirement budgets and other related activities in financial counseling.

7. Referring individuals for remedial training (if necessary) in reading, writing, and arithmetic.

8. Working with husbands and wives, and parents and children in reviewing and revitalizing relationships that may have been adversely affected by retirement.

9. Taking the role of the confidant for those needing support, encouragement, and someone to listen to them.

10. Serving as an informal teacher and/or speaker in such topic areas as preretirement preparation, retirement opportunities, and the range of leisure activities, in such settings as schools, business and industry, and meetings of civic, religious, and government employee groups.

11. Helping to facilitate the process of making a decision about where to live in terms of geographic location and types of facilities.

12. Collecting and presenting information on request regarding pensions, part-time work, and volunteer activities.

13. Acting as an advocate for older people and promoting their welfare by cooperating with local helping agencies for older people, offering suggestions regarding new programs, and assisting with program evaluations so that available funds can then be concentrated where they will be of the greatest help to the greatest number of older people.

14. Working with older people who are institutionalized or who are considering this possibility, and with their families.

Counselors working with individuals and groups of any age should facilitate the understanding of aging as part of a lifelong developmental process. Particular attention should be given to promoting an appreciation of older people and the opportunities in retirement as one means for countering negative stereotypes of older people. Developing a broader understanding of leisure as an important part of living for people of all ages is an additional objective to be kept in mind by all counselors. Developing skills in adapting to frequent change and in the decision making essential to successful adaptation is another objective pertinent to people of all ages.

Developing Relationships with Clients

In working with older people in any one of the potential crisis situations discussed in this module, professional counselors will be developing relationships with clients who may be considerably older, with environmental and cultural backgrounds substantially different from those of the counselor. Regardless of these differences, the basic requirement for counselors is that they be able to convey clearly their acceptance of and genuine caring for the client as a worthy human being.

Of special importance is the ability of counselors to understand and be sensitive to the general background of the client and the values s/he brings to the interview. Special effort should be made to understand the client's particular age cohort and the particular period in which s/he lived. Not to be overlooked are the possible negative reactions of the client to the dress, appearance, and conversational manner of the counselor if they are too different from the experiences and expectations of the client.

Clients may have a more favorable initial response to counseling assistance when they see counselors as being capable of helping them resolve a particular problem. In its resolution such a problem may require the counselor to give information or a direct service, such as transportation to a medical facility. When counselors have demonstrated that they are in fact helpers, the resulting relationship should enable them to address additional needs and more personal problems. In the process of establishing a positive relationship counselors must keep in mind that each older person is a unique human being, one who may or may not understand the counselors' roles or functions.

Some professional counselors believe that the selection and training of older clients as paraprofessional helpers is essential if the task of reaching even a reasonable percentage of those who need help is to be accomplished. At the same time, a substantial core of professional counselors must develop competencies in working with older people, not only to serve but also to train and supervise others.

Working With Specialized Care Facilities

In order to help older people adapt to adult congregate living facilities or to nursing homes, counselors must acquire a working knowledge of the purposes, organization, functions, and potentials of these facilities. Developing cooperative relationships with management will enable counselors to offer suggestions regarding the possibilities for encouraging positive behavioral change and to assist when appropriate, perhaps as members of case study teams that meet regularly to consider patient needs.

There are several ways in which counselors can assist directors and supervisors of specialized care facilities. One is to involve small groups of patients in reality orientation programs in order to demonstrate the possible positive results. Another is to conduct inservice training for staff to establish positive attitudes of caring and concern and encouraging actions that demonstrate these attitudes.

Working with Residents of Specialized Care Facilities

Residents often have desperate needs to establish personal relationships which say "I care," and "You are important" much better than words. Two other common problems illustrate the nature of the counselor's opportunities to work with this particular group of older people. The first is to help the client realize that each day is important in terms of human associations, helping others who are in the facility, and enjoying the beauty of natural objects.

In the case of families, an opportunity exists to help restore, when appropriate, broken ties that bring grief and despondency to patients and, at the very least, emotional strain to family members. The objective of the counselor often is to help the family and friends see how they can be useful in bringing happiness to patients. Outreach activities may sometimes be necessary to convince the family that they have a role to play in behalf of the patient. To be recognized is the fact that the activities of either counselors or family may have minimal visible effect in changing or mitigating the decline of the patient.

Individual/Class Activities

GROUP EXERCISE: PREPARING FOR RETIREMENT

A. Ask the class to form triads: one person to serve as company employee, the second, the company personnel office counselor, the third, the observer.

B. Roles

1. The company counselor's objective is to encourage the employee to consider actions s/he might take during the five-year period before the earliest time the employee could retire and receive pension benefits, in this case, 52.
2. The employee is a shop foreman making $20,000 a year, age 45, with two years of college, married, two children, one 22-year-old son, a university senior in accounting. The employee really doesn't want to retire at 52, but the pension plan is attractive.
3. The observer will record employee expressions of attitudes, arguments against retiring, and plans for retirement.

C. After about a 30 to 45 minute triad interview, the class will reconvene and the observers will report on the employee's attitudes about retirement and the preparation plans agreed upon. The class should have the opportunity to react and summarize.

GROUP EXERCISE: PLANNING FOR LEISURE (NON-WORK) TIME

A. The objective of this exercise is to expand counselor awareness of the diversity of approaches to planning constructive uses of leisure time by different age groups.

B. Resources

Avocational Counseling Manual (Overs, Taylor & Adkins 1977), with particular reference to sections on avocational activities.

C. Procedures

1. Ask class to form dyads, with one person taking the counselor's role, the other, the role of the older person interested in finding useful and interesting ways to use leisure time.
2. Suggest the following alternatives for those taking the older person's role:
    a. 50-year-old civil service worker who decides to shift from full-time to part-time employment for two years before full-time retirement.
    b. 64-year-old high school teacher who will retire at age 65.
    c. 70-year-old retired business executive who is bored with golf, fishing, and bridge.
    d. 70-year-old day laborer who has had a back injury that prevents further physical work. This person lives alone on a Social Security check.

   e. 80-year-old person who is terminally ill and in a nursing home, and is limited in movement to wheelchair or bed. This person is alert mentally and can talk with considerable ease.
   f. 65-year-old widow whose husband has died in the past six months after a happy marriage of 40 years.
   g. 52-year-old factory worker with a high school education, who retires because of job monotony. This person has few interests other than television.
   h. 60-year-old person who has spent 15 years caring for an invalid mother who dies. The person is physically and mentally exhausted and has few interests outside the home.

   Participants are encouraged to vary the given circumstances as desired.

3. After approximately one hour, the group or class will reassemble to share and comment on the experiences.
   a. Those taking the counselor role might focus on problems encountered in finding suitable alternative leisure activities to meet the client's needs and interests.
   b. Those taking an older person's role might concentrate on personal feelings in entering into the selected role, as well as reactions to the activities agreed on as constructive uses of leisure time.

   As a concluding element in this exercise, participants might list knowledge requirements for counselors working with client to develop leisure interests and summarize ways of overcoming any problems encountered.

GROUP EXERCISE: RETIREMENT

1. Organize two discussion panels to present personal views of retirement living, current activities, and recommendations to those about to retire:
   a. Panel One: three retired professionals, such as teachers (NRTA is a source); business executives (SCORE is a source); and government agency personnel (local government agencies are sources).
   b. Panel Two: three retired blue collar workers (local union offices may be sources).
2. Visit three local agencies that serve older persons to learn about purposes, functions, and effectiveness. At these agencies, interview part-time workers who have been retired, are either paid or volunteers, and discuss personal reactions to retirement living, current activities with the agency as well as other activities, and recommendations to those about to retire. Possible agencies include the Older Americans Center, RSVP, Foster Grandparents Program, and SCORE. Summarize the results at a class meeting.
3. Invite local professionals qualified to discuss biological, psychological, and social-cultural factors relating to retirement, to address the class. Possible local sources include community college faculty, members of the medical association, psychologists, counselors, and city planners.
4. Organize class into groups of 6 to 10 persons to simulate a task force with the objective of brainstorming ideas regarding developmental tasks most appropriate for the following age groups: 45 to 55, 56 to 65, 66 to 75, and 76 and over. The group may want to divide the last age group into 76 to 85 and 86 and over.
   a. Preparation
      1. Previous speaker(s) or reports on biological, psychological, social-cultural, and financial factors in retirement.
      2. Advance reading and perhaps discussion on developmental tasks. Sources: Arthur Chickering, Education and Identity, Chapter 1; Abraham H. Maslow, Motivation and Personality; Robert J. Havighurst, Developmental Task and Education (3rd ed.).
   b. Conclusion
      1. Each group should use a tape recorder to develop a group report.
      2. Group reports will be presented to the entire class for general comment and discussion.
5. Use same procedures listed in no. 4 above to discuss ideas and information regarding developing social status in retirement, developing new life styles in retirement, developing understanding about leisure and uses of leisure, and developing a model preretirement program (This topic should be covered following the panel discussion).
6. Arrange field trips for class members to local housing sites such as public housing projects for the elderly, foster homes, congregate housing facilities, congregate feeding facilities, retirement homes, and nursing homes. Make advance arrangements with the director or manager for the class to visit the facility with a facility staff member who can provide information. Topics to cover include purposes, functions, and special programs. Interact with residents to learn about their reactions to the facility and recommendations for any who are considering moving into the facility. At the next regular class, discuss the reactions of class members to the facility and to referring older persons to the facility.

7. When classes or groups include experienced counselors, the instructor or group leader should consider asking each counselor to develop a short-term counseling relationship with an older person, encouraging him/her to talk about any issues related to retirement, leisure, or living arrangements.

   Participating counselors should be asked to maintain informal journals as sources for class discussion of the problems encountered, techniques used, and results achieved. Depending on the situation, counselors might be asked to videotape portions of one client session for class review and discussion.

   If establishing a counseling relationships is not feasible, class members might arrange for informal interviews with older people, reporting in class on the individual's characteristics, adjustment to retirement, and progress in adapting to aspects of aging. Class members should be reminded of the importance of confidentiality and of obtaining permission from the older person to use the results of interviews in class.

GROUP EXERCISE: WHAT IS RETIREMENT?*

Time: 2 hours

Goal: To increase the awareness of the individual as to the meaning of being retired.

Objectives: To have each individual describe his or her own retirement and to discuss the many meanings of "retirement."

Method: Fantasy Exercise. Group members are asked to close their eyes and describe a typical day in their lives after retirement. The group leader should ask the group to focus on the following questions:

1. How do you feel upon awakening? Do you look forward to the day? Do you dread it?
2. How do you spend your day? Activities? With others? Alone?
3. What about the daily "chores?" Do you eat alone? Prepare your own meals?
4. How do you spend your evenings? Alone? With others? Active or passive?
5. What problems do you foresee?

The group should be encouraged to make notes on their feelings about each area. Form small groups (6-10) to share these feelings. Have each person describe his or her fantasy to the group. After members of each group have shared their feelings, ask each group to rate each other on how realistic the experience was. Each group should answer the following questions: Do I do this activity now? Do I spend any time this way now? Do I do things that will increase the likelihood of this life-style now?

The group should be encouraged to explore the need to do things now that will promote their chosen retirement life-style. Example: A person who projects spending time fishing should be asking if s/he now makes time for that activity. Ask each group member to be prepared to discuss any anticipated problems at the next group meeting.

Part 2: Preparations — Study Groups

Goal: To facilitate problem anticipation and preparation.

Objectives: To have each group member anticipate as many problems as possible, to share each problem with the group, and explore as many solutions-resources as possible.

Method: Have the group list all problems from the first part of this activity on the board. Add any problems that need to be included. Assign a problem or group of problems to small groups (6-10). If the group itself is small, assign each problem area to an individual. Each group should then make a list of ways in which this problem might be manifest and possible solutions to each. For example: The subject "living arrangements" might include such manifestations as housing, nursing homes, living with family. Each group should be asked to list the individual and community resources available to meet these problems.

Small groups should then report back to the group as a whole the problems anticipated and the resources available. Some groups may find there is a lack of information available and wish to explore reference materials. The resource material listed at the end of this program may either be made available to each study group or each group, time permitting, should be encouraged to solicit its own resource file. Each study group should be scheduled to present its findings in a future session.

The following broad topics are suggested for study group assignments:

1. Finances-income: If all members are under one employer, the group might describe the

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*Developed with the assistance of Barbara Shelton, East Texas State University.

retirement income provisions of the employer, as well as federal retirement income programs such as Social Security. If the group is from the community at large, members may wish to outline a typical private pension plan and the federal/state programs.

2. Personal assets and liabilities: How to maximize individual resources.
3. Living arrangements such as retirement housing, nursing homes, living with family.
4. Physical and mental health.
5. Employment-second careers: Opportunities for paid or volunteer work in the community. Ways to develop second careers.
6. Leisure: Use of, availability, cost.
7. Legal: Wills and estates.

Each group should be encouraged to make use of members' existing skills and talents. For example, a group comprised of retiring school district employees might be encouraged to develop private tutorial services to help students within the district. A roster of available volunteers in each subject area could be maintained in the counseling center.

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SUGGESTED FILMS

A Time to Learn. 16 mm, color, 30 minutes, 1973.

Reality orientation in 3 nursing homes in Tuscaloosa, Alabama is presented. Story of 2 activities directors and a nurse who have received reailty orientation training and started it in their nursing homes.

December-Spring. 16 mm, black & white, 29 minutes, 1973.

This is a University of Alabama film on Reality Orientation. It starts with a discussion on standard treatment of geriatric patients and goes on to discuss reality orientation. It covers general principles, definitions, and technique. Reality Orientation is geared to making patients feel at home and to master simple skills. The film also includes segments on special reality orientation classes.

Don't Stop the Music. 16 mm, color, 17 minutes.

Produced by HEW, Administration on Aging. This is a new film on the realities of aging showing that people move and live at different tempos that do not suddenly change at age 60 or 65. It challenges the myths and negative stereotypes of aging by letting older Americans speak for themselves. The film indicates the many ways that communities can respond to the needs of the elderly with greater awareness and involvement.

Step-Aside-Step-Down. 16 mm, color, 20 minutes, 1971. Sales Branch, National Audiovisual Center, Washington, D.C. 20409.

This is an HEW film dealing with the major problems of aging in America, such as income, housing, nutrition and transportation and private and government programs successful in solving them.

Weekend. 16 mm, color, 12 minutes, 1973.

A senile and invalid man is being put gently out to pasture by his family. The family of four (grandchild, the grandchild's parents, and the old man) have a picnic in the country, leaving behind their hot, stifling city apartment. In the peaceful meadow nothing at first seems out of the ordinary, but by the end of the day it is clear that the old man will not return with the others. He is left in the field sitting in his prized antique armchair. As the family car is pulling away, the viewer is permitted to see that the scene is being repeated all across the meadow. Other families are leaving their elderly behind.

Trigger Films on Aging. 16 mm, color. University of Michigan TV Center, 310 Maynard St., Ann Arbor, Michigan 48108.

This is a University of Michigan film dramatizing five different situations common to older people, designed to trigger discussion. The titles of five situations are "To Market" (2 minutes, 1 second), "Mrs. P." (4 minutes, 5 seconds), "Senior Center" (1 minute, 22 seconds), "The Four Minute Dinner" (4 minutes, 10 seconds), and "Tagged" (1 minute, 53 seconds).

To Live With Dignity. 16 mm, color, 30 minutes, 1972, University of Michigan TV Center, Ann Arbor, Michigan 48108.

This film documents a three-month project on disoriented and confused elderly persons requiring institutional care at the Ypsilanti (Michigan) State Hospital. Using milieu therapy adapted at the University of Michigan for confused geriatric patients, the hospital staff involved the patients in social interaction groups, group crafts, exercise, music therapy, and daily self-care. The treatment program was designed to enable nursing homes and geriatric wards of mental hospitals to use milieu therapy, adapted for frail and disoriented elderly people, at little cost and training.

Tell Me Where to Turn. 16 mm, color. Public Affairs Committee, 381 Park Ave., South, New York, NY 10016.

This film is designed to show how information and referral services help tear down the walls between people who need help and those whose job is to give help by bringing them together in the best interest of the community. It covers services to people of all ages, including the elderly. The film shows how the trained social worker can uncover unmet community needs and spur the creation of new services or the broadening of old ones.

The Rights of Age. 16 mm, color, 28 minutes, 1967. International Film Bureau, 332 South Michigan Ave., Chicago, Ill. 60604.

This film contrasts old people who enjoy the maximum benefits that society provides for them, such as Social Security, senior housing, Medicare, and a variety of social and recreational facilities, with those who suffer from illness, exploitation, economic deprivation, and neglect. It follows one such person, an elderly widow, as she moves from an existence of isolation and apathy to a promise of a more rewarding life. A doctor, psychiatrist, social worker, lawyer, and state assistance worker consult on the best ways to help the woman without taking away her prized independence.

Aging. 16 mm, 30 minutes, 1963. Indiana University, Audio-Visual Center, Bloomington, Ind. 47401.

Two elderly Jewish men playing cards reveal their attitudes toward life, loneliness, and the younger generation. A commentator discusses the stereotype of older people as functionless and recommends re-establishing the customary roles of grandfathers and grandmothers.

Evaluation and Assessment

1. The effectiveness of this module in enlarging the understanding of participants might be evaluated by the following procedures:

A. At the first class or group meeting, ask each class or group member to discuss in writing and turn in to the instructor or group leader a definition of retirement and the issues raised by retirement, a definition of leisure and the role of leisure in the life of older people, and a list of major objectives and roles of counselors working with older persons.

B. During the last class or group meeting, ask each class or group member to discuss in writing the same topics discussed during the first class or group meeting. (See above.)

C. The instructor and class or group members might join in comparing the two papers and determining areas in which learning may have occurred as a result of participation in the module.

2. Sample Essay Questions

A. Assume that you are a 45- to 55-year-old employed person concerned about retirement and you want to discuss what to do about it with a counselor. Review in some detail the topics you should consider and suggest a possible timetable for taking some action on each topic.

B. A person who is dedicated to his/her work and can think or talk about little else comes to you as his/her counselor. It has suddenly occurred to this person that s/he is going to retire in four years and s/he wonders with alarm what there will be to live for. As this person's counselor, how might you help?

C. A married couple will retire next year and they disagree about where they want to live. The wife prefers to remain where they have lived for many years; the husband wants to move to Florida. As their counselor, how would you help them approach this problem? What factors need to be considered?

MODULE V-C

DYING, DEATH, AND SURVIVORSHIP

Theodore H. Koff

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A former social worker and administrator, he developed and administered a long-term care facility for the elderly that included various levels of institutional and semi-independent care and day care services. He developed a continuum of long-term care services for the elderly and disabled for Pima County (Tucson), Arizona, which became an important model for other counties developing similar services. Dr. Koff was instrumental in the conceptual design and subsequent development of Hillhaven Hospice in the Tucson community providing a four-level care program for terminally ill cancer patients and their families, which, since its start in 1977, has gained national recognition.

He has lectured extensively and published articles on long-term care services, mental health in the aged, institutional design, and the care of dying persons. He is an educational consultant to a nationwide multi-facility organization with long-term care institutions.

He is a fellow of the Gerontological Society and past president of the Western Gerontological Society.

DYING, DEATH, AND SURVIVORSHIP

Rationale and Objectives

The actual dying phase of life is usually managed as a medical problem, but personal, social, cultural, and religious considerations are important factors in reactions to death. The counselor can help individuals or groups learn to deal with these.

The care of the terminally ill is incomplete without counseling, both for the dying person and the family. Often the focus has been only on the patient, but Kubler-Ross (1974) points out that the acceptance of death is often more difficult for the patient's family than it is for the patient him/herself. Help must be available to both.

Where can help be found? Often the dying person is literally flooded with personal contacts but has few people with whom to talk. Other times, the person is in effect deserted and is left isolated from the all-important human interaction s/he needs. At still other times the dying person finds true companionship in a loved one, a friend, a member of the institutional staff, a clergyman, a visitor to the patient in the next bed, or a counselor. The human being, who even though near death finds someone to talk to, someone who understands and can be helpful, receives a very special added quality to the ending of his/her life. Sometimes the counselor is fortunate to be this special person.

The relationship may be the chance occurrence in a case load, in a friendship, or personal life. Some counselors may elect to work in a health care setting and deal with death and loss frequently. Others may choose to work in a setting primarily dealing with terminal care where death and loss is ubiquitous.

Counselors may interact directly with dying persons and their close associates, augment the usual counseling role, or substitute an advocacy role of representing the needs of the dying person to others. Counselors also may become teachers and trainers of others, helping them to deal more effectively with the needs of the dying.

In order to be adequately prepared to meet and respond to the opportunity to comfort the dying person and his/her loved ones, the counselor needs varied skills. The life and death relationship is generally not predictable. None of us knows when we, our clients, colleagues, or loved ones will die.

What would their lives be like if the dying wanted someone to talk to but no one would listen?

The specific objectives of this module are:

1. To introduce the counselor to the settings in which counselors may encounter the dying.

2. To increase the sensitivity of the counselor to the health care team approach and to potential problems of territoriality.

3. To provide background information about the phenomenon of death in contemporary society and responses to the care of the dying and their significant others.

4. To make the counselor sensitive to the hazards of working with the dying so that the counselor can be both more helpful to the client and be more comfortable in dealing with the problems faced at the end of life.

5. To develop awareness of feelings and sensitivities regarding the counselor's own death.

6. To identify important counseling opportunities in the care of the dying, including direct client contact or activities on behalf of the client in an advocacy role.

7. To understand the needs of survivors and the importance of initiating early contacts with them and sustaining counseling.

Content

THE SETTING

Granted that it is now acceptable to talk about death, what if no one will listen? Can you envision a situation in which the impact of people like Kubler-Ross, Fulton, Feifel, Kastenbaum, and Kalish (all noted researchers on the American response to dying and death) has made it acceptable to discuss death in professional conferences, in classrooms, in inservice education programs for health care providers, and in scholarly journals and popular magazines, but where frequently no one is available to sit down and talk with a dying person about his/her own dying?

Where is the dying person dying? Who takes the time to listen, hold a hand, or provide some of the services the dying person needs? Might this be a situation in which everyone recognizes responsibility yet no one does the job? A dying person will seldom make an appointment to see a counselor in an office. The counselor has to be positioned somewhere along the "dying trajectory" (Kastenbaum 1972), or sequence of events in the dying process, in order to be responsive.

The dying trajectory can begin at an automobile accident, on the living room floor after a heart attack, on dark city streets after a mugging, or in the physician's comfortable consultation room after the diagnosis. It is unlikely, of course, that a counselor will be available in any of these settings. A more reasonable place to encounter the dying person will be in the hospital room where the counselor responds as a member of a hospital team, or as a support person from the local community mental health center, or as part of one of the new community specialty programs providing care for the dying. The importance of this encounter lies in recognizing that the counselor will not be the only one "counseling" the dying person, but will be one of a team of many health care providers responding to that person.

How does the counselor differ from all others? How will the dying person select him/her from among the other professionals or find out about the counselor's special talents? Titles alone will be insufficient because the dying person quickly learns what researchers have spent years studying—that too often the health care providers avoid talking about death, consider death a failure of their life-sustaining mission, cannot comfortably cope with their own feelings about death, and are ineffective in interacting with the dying.

For the most part (70%), deaths occur in the institutional environment of the hospital, nursing home, or hospice (Fulton 1976). Counseling the person about to die is always a highly individual experience, regardless of the social setting or environment in which the client is located. It cannot be assumed that one setting to die in is better than any other.

An important part of the counselor's introduction to a client is an appreciation and understanding of the client's environment and the meaning that environment has to him/her. If the counselor's own value system suggests that it is preferable to die at home, in the presence of loved ones and familiar surroundings, the counselor should determine whether home means the same thing to the client. The client's concern about home and family may make dying in an institution preferable, to avoid stress and discomfort for the family.

The counseling role with dying persons is usually performed by a staff member in a hospital or mental health clinic, a home health agency, a family counseling agency, or a specialty health or mental health service for the elderly. It may be advantageous for the counselor to enter the new relationship without previous association with the health care team that has attempted to keep the client alive. Being new, the counselor will not have been part of a losing team, in the sense that the client's impending death will not suggest failure on the part of a health worker.

A newcomer serving the client can bring a different approach to dealing with dying, to the family, and to the family's responses to a loved one's death. But first let us focus on the environment in which the client is placed and try to better understand the roadblocks that may be encountered in trying to provide important services.

Health Care Team

The physician is the leader of the health care team and has considerable importance and power in the client's life. The physician is involved in treatment programs, gives directions for the conduct of the client's treatment, and often holds the key to the client's hopes and desire to live.

It is especially important to find out about the physician, his/her style, his/her counseling the client, and his/her expectations. It is of utmost importance to know what the physician has told the client about the illness, prognosis, and life expectancy. Although this will not assure the client's understanding or readiness to accept a terminal prognosis, it is advantageous to the counselor to enter the counselor-client relationship aware of the physician-patient relationship. Does the client know the diagnosis, the prognosis of his/her illness, and the life expectancy?

Next, it must be remembered that the client will be deeply involved with an entire team of caretakers, primarily nurses, whether in a health care institution or at home. Again, it is essential that the counselor know the services being provided, something about the internal communications among the caretakers, and how the counselor is viewed by those currently providing the care. It would be valid and important to assume at the outset that counseling is going on, is being provided by others, and that the services of the newcomer—the counselor—may be viewed as a threat to the roles of others on the team. If those closest to the dying person (e.g., nurses) were in reality providing all the physical as well as psychosocial care, the separate services of a counselor would not be required.

However, an examination of the realities of providing care for the dying supports the contention that for the most part the psychosocial needs of the dying older person are not being met by the caretakers, that the focus of care continues to be on the physical aspects of care, and that counseling is indeed needed.

Since the counseling role and counseling services may not always be understood, welcomed, or supported, the counselor must understand the dilemma of other caretakers and not participate in a situation, even unknowingly, in which the client bears the burden of indecision, of role and function confusion, or loss of support of helpful caretakers.

The Counselor's Role

At the outset the counselor must understand the environment in which care is being provided and should know the roles of all caretakers. The counselor's role may, therefore, vary with the realities of the care environment and may include some or all of the following:

- Counseling with the client, with client defined as the dying person him/herself
- Counseling with the client, with client defined as the dying person plus family members or significant others
- Counseling with survivors during the bereavement period.

Counselors are needed to provide warmth and human concern for the dying older person. The counselor's skills and talents will be helpful to individual clients, to their relatives, and to clients and family members in groups. To some extent this is the traditional role for counselors in any setting, and this is as it should be. Dying older people are first and foremost people who deserve the support of the counselor where it is needed.

There will, however, be situations where the dying person is not in the most appropriate or responsive environment, where a counselor is not part of the service, is unwelcome, and is seen as an outsider. This may be a setting where the health care team is not functioning with unity and purposefulness on behalf of the client or where the client has lost personal control over the dying experience as a result of the absence of appropriate understanding and sensitivity on the part of the caretakers.

Power, or mastery over one's fate, is a positive force in any human life, regardless of age or level of disability. Personal freedom in decision making, the availability of alternatives, and opportunities for independence should be considered innate human rights that may require special effort to safeguard and sustain for the dying. The dying person may need the support of a counselor to maintain control over his/her own life and therefore his/her own dying.

Control over one's own life, often reflected in personal decisions, is an important part of human existence. It becomes no less important for the dying person, but often is less clearly recognized because of the apparent dependency of the dying person, his/her proximity to death, or the caretakers' lack of appreciation for sustaining control throughout life. Often, counseling services are not adequately extended to the older dying person because s/he is nearing the end of his/her life and the caretakers experience feelings of helplessness in dealing with death (Koff & Koff 1977).

The counselor's role may also include meeting the needs of people who work with the dying person as well as challenging the care system to be more responsive to the needs of the dying person. Here, instead of counseling the client, the counselor directs his/her efforts on behalf of the client, calling on professional insights and skills to challenge the consciences of others. This is an example of advocacy for the dying older person.

The counselor may advocate for effective institutional responses, for consistent interpretation of the client's prognosis, for reuniting estranged family members, for the involvement of the dying person in decisions affecting his/her own life. Whatever the course of the specific advocacy position, it will enhance the esteem in which the counselor is held by others when that counselor is seen ready to represent and do battle for the rights of the dying person. The counselor needs to appreciate that advocacy — especially when it stems from the specific request of the client rather than from the counselor's advocating a counseling role — is an essential component of the counselor's responsibility to the dying client. To assume this role appropriately, the counselor must know the client and the environment in which the client is dying and must become the client's advocate as a part of his/her counseling responsibility.

Because the counselor not on the institutional staff may be seen as an interloper into the health care team, several suggestions may be helpful in enabling the counselor to become a contributing member of the team, thereby gaining opportunities for effective advocacy on behalf of the client. The first of these suggestions deals with the availability of the counselor, especially during nontraditional work hours. Counselors who function only during the day, Monday through Friday, cannot effectively function as part of the care team for the dying.

Suggestion #1. Counselors need to be available (and should make their availability known to the health care team) whenever the client, family, or health care staff requests. If the counselor is always available to work with the health care team, s/he will learn more about the team members and their methods of functioning and will discover appropriate opportunities to make a contribution to the team. The health care team that functions with shared goals and openness with one another in a supportive way will in time become more sensitive to the needs of the client. Conversely, strife or disruption of a team effort can only distract from the focus on the client's needs.

Suggestion #2. The counselor should be prepared to offer supportive intervention to members of the health care team to ease the staff's burdens in dealing with death and dying, to help in team building and communication among team members, and to strengthen the sense of a shared mission or community among the health care team members. It is important for the counselor to know whether team building and staff support have been defined as the responsibilities of other staff personnel before assuming this role. The counselor should validate his/her team-building role through the feedback of team members and should respect the right of team members to reject the counselor in this role.

Another important role for the counselor in asserting advocacy and strengthening relationships with the health care team is that of educator. As educator, the counselor can help team members deal with their own feelings about death and dying, can define a framework for team functioning, can assert the rights of the dying person, and can establish an environment from which the client can obtain the necessary care and caring.

Suggestion #3. Counselors should be prepared to assume major responsibility for an ongoing educational program to help all caregivers function most responsively to the needs of the dying person. (See Appendix A for sample models of educational training programs.)

Hospice — A Special Setting

Although it has been noted that most people die in institutions and that this incidence increases steadily each year, it cannot be claimed as a consequence that death in an institution has become more humane. Probably not until the advent of the hospice — a total care program for the dying — was the institutional environment challenged to examine and improve its responses to the dying person. Although few people may die in a hospice and not all hospice programs provide the same orientation or services, the hospice program as developed at St. Christopher's Hospice in England and similar programs now functioning in several communities in the U.S. have some important messages for the care of the dying.

In the context of this module, counselors, family, and institutional staff have much to learn from the hospice. Ideally, counselors interested in the dying would seek employment in a hospice. The small number of hospice programs in the U.S. make this impractical, so the greater challenge today is to interject the qualities of the hospice program into the environments where most people die.

What have we learned from the hospice movement that is applicable to counseling?

1. It is difficult to die, to deal with the many issues of dying, or to engage in helpful counseling relationships when the client is beset by severe pain or other discomforting symptoms. The initial function of the hospice program requires the alleviation and prevention of pain.

2. Once the successful control of pain and other discomforting symptoms is accomplished, the aggressive search for the treatment of the illness is replaced by palliative care of the symptoms. The goal of the hospice is to provide patients and their families with as tranquil, supportive, and as dignified an experience as possible (Hackley 1977). Options for the dying are few and opportunities for meaningful experiences are limited. Therefore there are no restrictive visiting hours; family, friends, and pets are welcome any time of the day or night; all personal requests receive a prompt response and every effort is made to provide meaningful service that supports the patient's sense of worth.

3. The patient and family are a unit; the same positive concerns should be displayed for every one of its members and should be extended to include further support and care for the family during the bereavement period. "The hospice is a therapeutic community within the community, helping the dying to live until they die, and helping families to live on" (Will 1978, p. 72). Family members should not only receive care, they also should be involved in care giving.

4. A structured staff support and communication system is an integral part of the hospice design and is acknowledged to be essential if the staff is to deal with the repetition of loss and grief. The problems a dying patient and his/her family face are myriad and no one person is going to be able to deal with them all. Volunteers play an important part in the resources made available to the patient

and, consistent with the team approach, volunteers are appropriately screened, selected, and trained to enhance the services provided by staff.

Counselors should be familiar with these hospice concepts and would benefit from seeing them in practice. Hospice experiences could influence the goals of all health care environments dealing with death, with the counselor serving as a guide and advocate for the adoption of hospice procedures.

THE PROCESS

Counselors' Attitudes

One caveat is in order. Counseling with the dying person can be one of the most difficult, soul-searching experiences the counselor will ever assume. The counselor may witness the physical breakdown of a human being beset by pain, physical deterioration, emotional distress, and family upheaval. The counselor may suffer repeatedly from the loss of loved ones who become reminders of his/her own mortality, possible deterioration, dependency, and death.

Sensitive counseling skills are needed at the bedside of the dying person to reaffirm the importance of life and living even for the dying. Because so many who minister to the needs of the dying find it difficult to deal with dying and death in a supporting, comfortable relationship, it becomes incumbent upon those who counsel the dying to concentrate their energies, to pick up the load, and to create greater expertise and commitment despite the potential hazards.

Can counseling with dying persons be hazardous to life? How many deaths can an individual tolerate? Counselors ask, "Will it get too depressing? Will I be immobilized? Will I burn out? Will I become immune to human suffering and trauma?" Potentially, the answer to each of these questions is "Yes." The counselor who works with dying persons must be prepared to "die a million deaths," to suffer the pains of each loss, yet return to respond to the needs of the next client.

Obviously most counselors might choose not to specialize in the care of the dying or even deal with an occasional encounter with death. This can be readily understood. Although our society openly encounters death in literature and the arts it has not yet dealt with meaningful personal encounters. Death is hidden in health care institutions, disguised in mortuaries and glorified in memorials and obituaries, but is not dealt with comfortably and realistically as a part of living.

One's first encounter with death makes a deep and lasting impression. Was it with farm animals and pets? Was it with an aging member of the extended family whose death strengthened the bonds of the entire family? Did death occur in the presence of a loving family appreciative of the opportunity to care for the dying person? Or was death first observed on the TV screen, obviously touching the emotions of those involved but not being integrated into personal experience? Was death first observed as a shallow, superficial, destructive, distant event or as part of a loving, caring, personal relationship?

Obviously, this forced dichotomy of first encounters with death may not accurately reflect the experience of any one individual. It suggests, however, that the environment in which the counselor first learned about death probably set the stage for the response toward working with the dying and his/her capacity to maintain a caring response in the frequent presence of death. This is not intended to suggest that early experiences preclude personal growth or changed response. But the counselor preparing to work with the dying client will have a greater capacity to survive and be helpful if s/he has had ample opportunity to deal with and develop a personal attitude that permits him/her to respond to dying and death without paying a large personal toll.

While first encounters are important to begin this process, what were subsequent experiences and when did they occur? Discussions that help the counselor understand his/her own behavioral response to dying may begin with inquiries about first and subsequent encounters with dying: the people involved, the age of both the counselor and the person dying, the environment in which the encounter occurred, the response of other persons involved, and the counselor's experience in dealing with the event.

The counselor's response to death is also nurtured by societal values, by continuing exposure to death, by a continuing commitment to the qualities of life and by the humaneness of the helping relationship. Death has become a mystery to most of us (Feifel 1977a) and is treated distantly by a variety of professionals.

Society's Attitudes

Feifel (1977a) characterizes the current ethos of death and dying in our American society as having the following characteristics:

1. We no longer command philosophic or religious creeds with which to transcend death. A belief in personal immortality has been transferred to a social or historical immortality, represented

by our continuity through children, acts of goodness, or contributions to others. The atomic age threatens to destroy the social and historical continuity, leaving us with no concept of immortality and therefore without the possibility of atonement and salvation that are implicit in the belief in a personal afterlife. Death, instead of serving as a door, has become a wall.

2. Death has become uncomfortable for us because of the increased fragmentation of the modern family. Death has become the province of the professional caretaker rather than members of the family or community. The mastery of death by professionals has become technical rather than human, making it increasingly difficult to respond to death as a human experience. The dying person is left to die emotionally, spiritually, and physically alone.

3. Advances in medical knowledge have changed the nature of the causes of death and therefore the dying process and the average age of the dying person as well. Death has been associated more emphatically with aging and age-related diseases. The time span of dying has been lengthened, increasing the period of pain, fear, family trauma, and uncertainty. The introduction of death-defying health care practices has dehumanized the dying process, further alienating family from the dying person and reinforcing the role of the caretaker as technician.

4. The difficulty of dealing with death as a phenomenon of old age is increased because of our society's generally negative attitude toward the aged and its inability to deal with a future that is seen as a short time period. The dying person's future is a reality and must be acknowledged by caretakers and controlled by the dying person whose future is involved.

A Helping Framework

How will the counselor know if s/he is suited for counseling the dying? How can the counselor learn to deal with the difficulties of this counseling relationship and to be helpful to the client?

Harper (1977) has conceptualized a helping framework for the counselor who appreciates the trauma, pain, and uncertainty encountered in working with death. This framework is a useful tool for both counselors and supervisors of counselors and, therefore, for counselor educators. The Harper paradigm begins with the premise that the counselor is ill prepared for encounters with death by either his/her personal background or professional training and will not know how to deal with the uncertainties and anxieties that must be confronted. This requires an adjustment period, a time for reflection, feeling and working through feelings about this specific counseling role. Such a process enables the worker to gain the knowledge and strength necessary to direct his energies into a "new human caring dimension" (Harper 1977).

The paradigm, similar to those of Maslow and Kubler-Ross, is organized into a process of time and growth and is illustrated in five stages. It requires approximately 24 months to complete. This schema is titled "Coping with Professional Anxiety in Terminal Illness" and the growth sequence is referred to as the "line of comfort-ability" (see Figure 1).

Harper (1977) offers her own paradigm for professionals working with the dying because

> professionals ... do not enter practice academically, intellectually or emotionally prepared to deal with death and dying. They must learn to cope with professional anxiety arising from such experiences. This requires an adjustment period for the professional, a time for working through his own feelings about death, dying and life's end.

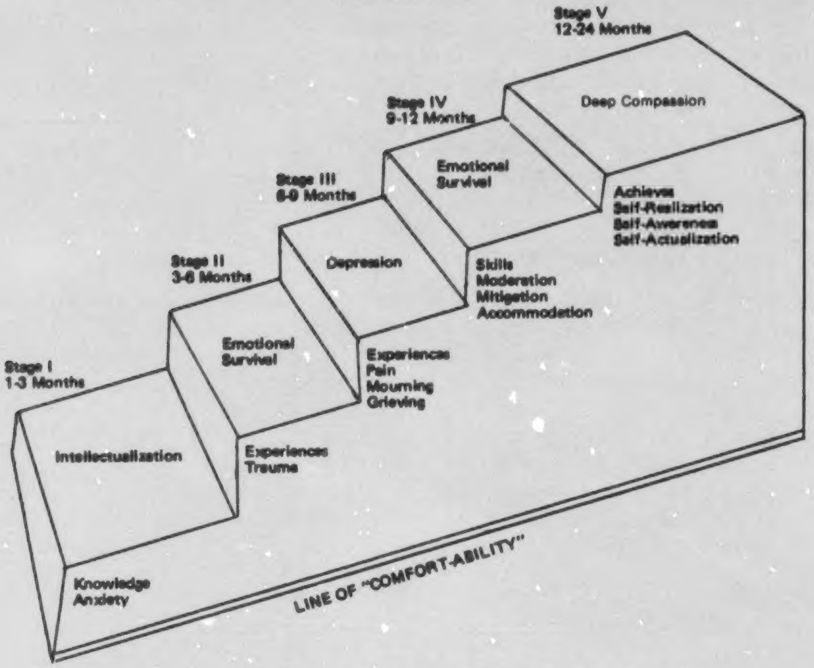
Counselors go through an adaptive process in order to become comfortable. It therefore is helpful to identify the process so that it can be taught and used by counselors. The worker gains understanding, knowledge, and strength and works through conflicts, both internal and external, adding a new human caring dimension to his/her existing capacity to be helpful — this is the maturing of the health professional.

Stage I: Knowledge and Anxiety. This is the initial period of encountering the dying at which workers are anxious to serve and are concerned but uncomfortable. Tangible requests get priority, with intellectualization rather than emotionalism dominating the method of handling the problems. The worker is not yet prepared to let the client talk about death and dying or raise sensitive questions.

Stage II: Emotional Survival. The counselor experiences traumas accompanied by quiet and frustration; through these feelings the counselor confronts the realization of his/her own eventual death. Guilt and frustration are evoked because the counselor lives on in good health and witnesses the deterioration of his/her client. The counselor realizes the reality of impending death for the client. Recognizing his/her inability to arrest the process, s/he wants to fight back and is jolted out of the inertia of intellectualization into the emotional involvement accompanied by emotional growth.

Stage III: Depression. In this stage the counselor experiences extreme anxiety, grief, and depression. Usefulness and capability are questioned. This stage is referred to as the "grow or go"

FIGURE 1
Coping with Professional Anxiety in Terminal Illness


Stage V
12-24 Months
Deep Compassion
Achieves
Self-Realization
Self-Awareness
Self-Actualization
Stage IV
9-12 Months
Emotional Survival
Skills
Moderation
Mitigation
Accommodation
Stage III
6-9 Months
Depression
Experiences
Pain
Mourning
Grieving
Stage II
3-6 Months
Emotional Survival
Experiences
Trauma
Stage I
1-3 Months
Intellectualization
Knowledge
Anxiety
LINE OF "COMFORT-ABILITY"

From: *Death: The Coping Mechanism of the Health Professional*, by Bernice Catherine Harper.

Stage Characteristics and Differences of the Schematic Growth and Development Scale

Stage I	Stage II	Stage III	Stage IV	Stage V
Professional knowledge	Increasing professional knowledge	Acceptance of professional knowledge	Acceptance of professional knowledge	Refining of professional knowledge
Intellectualization	Less intellectualization	Decreasing intellectualization	Normal intellectualization	Refining intellectual base
Anxiety	Emotional survival	Depression	Emotional arrival	Deep compassion
Some uncomfortableness	Increasing uncomfortableness	Decreasing uncomfortableness	Increasing comfortableness	Increased comfortableness
Agreeableness	Guilt	Pain	Moderation	Self-realization
Withdrawal	Frustration	Mourning	Mitigation	Self-awareness
Superficial acceptance	Sadness	Grieving	Accommodation	Self-actualization
Providing tangible services	Initial emotional involvement	More emotional involvement	Ego mastery	Professional satisfaction
Utilization of emotional energy on understanding the setting	Increasing emotional involvement	Over identification with the patient	Coping with loss of relationship	Acceptance of death and loss
Familiarizing self with policies and procedures	Initial understanding of the areas of practice	Exploration of own feelings about death	Freedom from concern about own death	Rewarding professional growth and development
Working with families rather than patients	Over identification with the patient's situation	Facing own death	Developing strong ties with dying patients and families	Development ability to give of one's self
		Coming to grips with feelings about death	Development of ability to work with, on behalf of and for the dying patient	Human and professional assessment
			Development of professional competence	Constructive and appropriate activities
			Productivity and accomplishments	Development of feelings of dignity and self-respect
			Health interaction	Ability to give dignity and self-respect to dying patient
				Feeling of comfortableness in relation to self, patient, family and the job

From: *Death: The Coping Mechanism of the Health Professional*, by Bernice Catherine Harper.

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stage, because if the frustrations and pain are too great or not adequately rewarded, if grieving and mourning are overwhelming and the counselor cannot grow in personal strength and capacity it is better for the counselor to go.

At this time the question "Isn't counseling the dying depressing?" is frequently encountered. It must be answered strongly in the negative by the counselor who is to survive. The counselor at this stage should be concerned by the dilemma of the dying person who lacks a counselor's services or appropriate responses from the health care providers. If opportunities for counseling the dying are viewed as exhilarating and enriching the counselor is ready to go on to Stage IV.

Stage IV: Emotional Arrival. This stage is marked by a sense of freedom from the debilitating effects of pain and grief. The counselor has the resilience to recover and has the control to practice his/her art. The counselor is freed from identifying with symptoms and with guilt and is no longer preoccupied with his/her own death. Instead, sensitivities have increased and though not free from pain, s/he is free from its incapacitating effects.

Stage V: Deep Compassion. This stage is characterized by self-realization, self-awareness, and self-actualization and is the culmination of all of the growth and development that has previously taken place. The counselor now has the willingness and capacity to serve the dying, coupled with a feeling of his/her own worth that communicates comfort and respect to the dying person.

This systemization of the coping mechanism for counseling the dying has implications for counselor education. As for other stage theories, the usual admonitions against the requirement that every student conform to the same sequencing, time frame, and product should be made. Harper's schema is valuable nonetheless, offering a goal for counselors as well as a goal-oriented sequence of events. Furthermore, it helps the counselor who is leaving the cycle find the best time to jump off.

All counselors need not counsel the dying. It is to be hoped that all counselors will deal with their own mortality and will therefore think about the meaning of their own lives. This process should make them more effective practitioners.

THE COUNSELOR

The counselor generally arrives on the scene at a time of heightened stress and conflict. Where should s/he begin? What should s/he say or do? Before saying or doing anything, the counselor should learn and observe. First, the counselor should immediately find out the client's diagnosis and the prognosis for life expectancy. This information may be available from the medical records in a health care institution or from the medical or nursing staff. The counselor should augment the basic information with an understanding of the anticipated course of events for a particular diagnosis. This will add to the counselor's understanding of what is likely to occur and how the client might respond to the changes.

Second, the counselor should find out what health care providers, clergy, or friends are involved or are resources to support the dying person. In addition, members of the family should be identified and their involvement noted. The counselor needs to know how family members cope with crisis, the extent of their knowledge of the illness, the diagnosis, and the prognosis.

Third, it is important for the counselor to know about the religion, culture, and ethnicity of the individual and family because the belief system will influence the ability to deal with illness and death. (Refer to Module VI for a more in-depth exploration of counseling minorities.) The selection of care providers, the sophistication of knowledge about the illness, and responsiveness to counseling may also be influenced by the client's educational background as well as by the belief system. Some people will seek nontraditional healers and treatments to augment or displace traditional health care. Others may assume that their terminal illness is a punishment for some behavior and may need to deal with feelings of guilt as well as with dying.

The counselor should observe the client's discomfort and pain. It is too difficult to deal with relationships, or the future, or life itself if the person is beset by intense pain. Symptom control must be accomplished before the client can engage in meaningful counseling exchanges (Lack 1977).

The counselor should observe the room, the physical environment, and the person's comfort. How adequate is the size of the room, the lighting, the furniture? Are there flowers, mementos, personal belongings, greeting cards, religious objects, pictures of family? What can be learned from the patient's environment about friends and visitors, about social interaction or isolation?

The counselor should observe the client's response to being introduced, to having the counselor's function explained, to being offered help. Is the counselor's presence anticipated, welcomed, acknowledged? Does the counselor's visit create increased anxiety?

The counselor should note the person's body language and other physiological functions. S/he should notice the musculature, hands, jaws, and facial muscles, and should observe whether respiration is shallow or increases in the visitor's presence.

Having observed the person and the environment, the counselor is ready to focus on the client's needs and to provide the skills and responses the client requests. When dying patients are asked what can be done for them, they will, depending on the response of other staff, ask for help in getting rid of the pain, in providing care for the family, or in handling the insurance papers and details (Lack 1977).

Dealing With the Dying

Because many older persons die in institutions, those who reside there have many opportunities to observe the way dying is treated. Each individual thus learns of his/her own potential fate, and each death becomes an anticipation or rehearsal of his/her own dying. Individuals prepare for anticipated trauma by rehearsing in their minds the sequence of events and the responses of others related to them. By reviewing and sorting out the situation, this "worry work" becomes productive because it provides a rehearsal for coming events. Counselors must recognize the value of this social rehearsal for dying as a process in which the institutionalized older person is an active participant (Koff 1975).

In many institutional environments, attempts are made to disguise or hide the deaths of occupants. The message is clearly given to surviving residents that the life of the deceased was insignificant because his/her death is not commemorated in any way. The surviving person learns that his/her death will be treated in a similar fashion. Instead of being hidden or disguised, death and dying should be dealt with openly. Institutional practices should be scrutinized and counseling assistance provided to each resident to help him/her determine how his/her own death will be handled.

Even though an effort to involve the dying person in planning is made, some individuals may wish to avoid discussing death and dying. This wish must be respected, but it should be realized that the wish does not necessarily mean the person is not observing and rehearsing his/her own death (Koff 1975).

"Sometimes it just takes companionship and care. You do not desert people who are ready to talk. If you simply sit with them and continue to show you care . . . they will occasionally open up without a word spoken" (Kubler-Ross 1974).

The counselor not only must learn and observe, s/he must very sensitively listen. This is all the more difficult for the person whose training and background emphasize verbal communication and interpersonal intervention. To sit quietly and listen requires great skill. What is essential is to respect the client's choice, to relate silently to him/her while s/he sorts out ideas and feelings. The client is aware of the counselor's presence and thereby avoids feelings of isolation or desertion.

Remaining patiently at the bedside of the client in the absence of conversation further demonstrates the counselor's dependability and ability to focus on the client's needs. Such continued commitment to the client demonstrates the counselor's devotion. The client will know this and use the counselor when s/he is ready.

There is a place for humor in responding to the dying; it helps make dying a part of the total living experience. Reminiscing about humorous events in life can comfort and open communications with the dying person. The ability of the dying person to deal with humor, if it is in keeping with his/her life style, is also an opportunity for maintaining control, as exemplified by the following anecdote:

> An old woman was dying at home. At the moment when she was apparently about to die she was in bed, head propped up on some pillows, eyes closed. A large number of her family were standing around in stony silence waiting for her death. The old woman opened her eyes, scanned the scene, and said softly, "A watched pot never boils."

THE DYING PERSON

So I'm dying!
So what?
Others have died before.
So what's different about my death?
But it's me!
It's my life!
Let me tell you about my life.
Don't look at me for what you see,
See me for what I am.
Where did the years go — time flew by so fast.

Open your eyes, my friend
Look closely and see me.

"Within every person is a distinct and unique being that is unlike any life that has existed before or will ever exist again" (Moustakos 1977). How can this uniqueness be maintained in spite of illness, old age, or feebleness? How can this uniqueness find expression in the care system for the terminally ill? There probably is no single way to express the essence of individuality, but the individual must continue to believe in him/herself.

Isolation

In near-death situations the individual's growth, integrity, and uniqueness are fostered principally through interpersonal relationships. The counselor is especially important as s/he assists in maintaining existing relationships, supports the establishment of new relationships, and adds him/herself to the list of significant new relationships.

The counselor can chart the nature and frequency of social contacts for the client, questioning whether they are of the preferred quality and quantity. The counselor will know how to be helpful based on the client's responses. One of the major concerns expressed by dying patients is the fear of being deserted. Old people dread rejection, isolation, and loneliness more than they fear death (Golda 1977). Although studies about the fear of death among the elderly yield contradictory results, the dread of loneliness and anxieties about becoming isolated are consistently present.

Wass (1977) reports that older people want to talk about death. The reluctance of people to discuss death and dying with the elderly because such discussion might be upsetting is unfounded. Patients facing death can also feel cut off and shunned by the living. Patients in the final phase of their lives are not only dying, they are also living and can be sustained in their living through interaction with others, through life-stimulating experiences, and by being considered a part of the living world, especially in our society where the elderly and the dying are segregated.

Isolation is increased by the inability to discuss their terminal illness and expected death with others. The fear that friends or staff will be frightened by their dying and the anxiety about discussing death causes greater feelings of isolation in their desire to avoid a rejection of social contacts. Visitors often report their anxiety about not wanting to be present at the moment of death. Unquestionably, this is counterproductive to the social responses to the dying person.

Keeping the client ignorant of his/her condition demonstrates a lack of confidence in the ability of the client to deal with his/her own life. The way the client is told of his/her condition is important, along with the readiness to deal with this issue. The question is not whether to tell the client, but when and how. Staff, visitors, and family will all communicate the message of terminal illness nonverbally. The client will observe and respond in varying ways.

Many older dying persons suffer from devaluation, not just disease, as a result of their being assigned to the sick role rather than the dying role. The sick role was described by Parsons (1955) as exempting the sick person from social and work responsibilities while being cared for as a result of the illness.

Both the sick and dying roles are time limited and defined by physician authority. In addition, both roles maintain for the individuals occupying them the continued respect and status of their community. Beyond this point there are important differences. The duty of the sick person is to desire to get well; that of the dying person is to desire to live as long as s/he can. The sick person has the right to be cared for and is encouraged to become dependent. The dying person is also entitled to care but is encouraged to become independent within limits. Although both sick and dying persons are exempt from social responsibilities, the dying person is permanently freed from them and is allowed to disengage from family and community (Noyes & Clancy 1977).

Confusion of the roles is seen in inappropriate active medical treatment prolonging the suffering and disability of dying people, in the silence regarding the prognosis because the dying person is judged too frail or vulnerable to cope with the anticipation of death. Caring for the dying person in the hospital also marks a confusion with the sick role because hospitals are primarily oriented toward diagnosis and treatment.

If the dying role is clearly established and understood the dying person can get on with the tasks related to dying, such as the completion of business affairs, writing a will, leaving bequests, and funeral arrangements. Of great importance is the ability to assume control of the decisions affecting his/her life for as long as possible.

The older person going through the process of dying is not only dying but also ending a life. Is there a difference between the two? Dying connotes of illness, hospitals and caretakers, pain and stress. Ending a life can be like the end of an important book, when you look forward to the completion and fulfillment of the total experience. Both of these processes converge at the end of life. Too much attention has been on the process of dying; more attention should be given to the completion of the unique life experience. What has life meant to the person about to end his/her life? What has it meant to others? Is there time and opportunity to stimulate a life review before death?

Life Review

Butler and Lewis (1973) say that reminiscence in the aged is

> part of a normal life review process brought about by realization of approaching dissolution and death. It is characterized by the progressive return to consciousness of past experiences and particularly to resurgence of unresolved conflicts which can be looked at again and reintegrated. If the reintegration is successful, it can give new significance and meaning to one's life and prepare one for death, by mitigating fear and anxiety.

This life review can occur in a less intense form through nostalgia, mild regret, a tendency to reminisce, story telling, and the like. The person will often tell his/her life story to anyone who will listen. As part of the life review one may experience a sense of regret that is increasingly painful. In severe forms it can yield anxiety, guilt, despair, and depression. The most tragic life review is that in which a person decides his/her life was a total waste.

"Some of the positive results of reviewing one's life can be a righting of old wrongs, making up with enemies, coming to acceptance of mortal life, a sense of serenity, pride in accomplishment, and a feeling of having done one's best." (Butler & Lewis 1973). The life review is an important process counselors should be familiar with and prepared to stimulate in all clients. Counselors should find the opportunity to develop skills in life review by rehearsing with small groups of active older people. They may be available in senior centers or senior educational programs where life review experiences can begin with individuals who are not confronting death.

Although life review or reminiscing can be conducted with individuals or groups, for people close to death it is suggested that it be handled in small, intimate groups or between a counselor and client, when possible including family members. "Tell me about your life, family, friends, work" is an easy opener to communicate your interest in knowing more about the client. Even more important is committed listening, interaction, and continuity. Encouraging the person to talk about and reflect on his/her life provides an opportunity to recall, reflect, and organize life's experiences in a useful way. No one else can do this for the dying person. The presence of others helps focus on some events, provides feedback, and makes the life events more important because others listen and share.

Kubler-Ross Stages

Through her clinical practice with dying patients, Kubler-Ross (1969) has developed a framework of stages in dying that provides useful background for the counselor's better understanding of the dynamics of dying.

> The stages begin with 1) shock and dental. In this stage the patient says, "No, not me." He or she may simply be numb and appear completely unaware of the bad news, disagree with the diagnosis or remain oblivious to its implications. Denial may persist for moments or pervade the rest of the person's life. More characteristically it fluctuates, waxing and waning over the course of the illness. 2) In the stage of anger the patient now says, "Why me?" Angry outbursts may be directed toward hospital menus, treatment regimens, physicians, families, life in general, or God. Past life may be reviewed, usually with inability to find oneself at fault for hygienic or moral reasons. A sense of unfairness, frustration, and helplessness generates a normal sense of outrage which in turn may give way to periods of bitterness. 3) In the stage labeled bargaining the patient now says. "Yes, it is me, but...." In this part of the process the patient puts a condition on acceptance, such that he hopes or plans for something that can mitigate disappointment. The characteristic hope would be that life be extended until a special event occurs, such as a wedding, birth, graduation, and so forth. 4) In the stage called depression the patient's attitude can be summarized as "Yes, it is me." At this time they may do a good deal of weeping, are intermittently withdrawn and uncommunicative, brood, and are weighted down by the full impact of their condition. Despair and suicide are common preoccupations during this time. 5) The final stage of acceptance is conceptualized as a state reached through emotional work, such that losses are mourned and the end is anticipated with a degree of quiet expectation. It is seen as a restful albeit weary time, almost devoid of feeling.
>
> The notion of stages is by no means new and is not restricted to dying. As a dynamic process, dying is merely a special case of loss and the stages represent an excellent dynamic

model of emotional adaptation to any physical or emotional loss, even of a rather minor nature. A common misdirection in caring for dying patients is the attempt to help an individual get through the "stages" one after the other. It is more accurate and therapeutically far more practical to regard the stages as normal reactions to any loss. They may be present simultaneously, disappear and reappear, or occur in any order.

The counselor should not hold the client responsible for going through all or any of the Kubler-Ross stages. Rather, the counselor needs to understand that these stages represent the sequence of events that occur for many dying people, that s/he can be more understanding of these stages as they occur and therefore can be more comfortable in accepting the client's need to work through these stages to acceptance of death.

SURVIVORSHIP

If the counselor initially understands that the client is both the dying person and the family then s/he can continue to assist the survivors; there is no question of the validity for continuing services to a family. If counseling continuity with survivors is anticipated, the counselor can initiate plans for after-death care in order to provide a resource for the family.

The list of details to be handled and decisions to be made is long; they will only grow in intensity if they have to be resolved during the emotional upheaval of death and loss. The counselor can be helpful in getting as many decisions made in advance of death as possible. They will be especially meaningful if they are made by the dying person and shared with the survivors. Get as much in writing and implement as many details as possible, so that a network of services will be prepared. Details may include: kind of burial requested; selection of grave and mortuary; selection of minister; outline content of service; invitation list to the funeral; beneficiary authorization for all assets, including safe deposit box; written last will and testament; disposition of property, clothes, personal possessions; list of debts and assets; people to be advised of the death; memorials.

The individual who can arrange for these details maintains control over his/her life to the very end. Funeral directors can often provide a planning checklist of details frequently encountered after death.

How do you feel about tending to post-death matters while the subject is still alive? This is another personal involvement question counselors need to deal with while respecting their client's rights to plan ahead or to avoid encounters with after-death affairs until after the death occurs.

The death of the older person changes the locus of attention from the deceased to the survivors. There may be an outpouring of emotion, but unquestionably there is a sigh of relief that the suffering is over and the traumatic part of life is ended. Survivors are not yet exposed to the loss and loneliness because of their focus on financial affairs, family, and visitors.

Bereavement, Grief, and Mourning

Kastenbaum and Costa (1977) define bereavement as indicative of survivorship status. It tells nothing about the survivor's actual response to the loss. Grief is the expression most often used to characterize the survivor's distressed state. Mourning refers to the culturally patterned manner of expressing the response to death. Styles of mourning vary with the culture and religion and background as well as change with time. Specific styles of mourning are associated with ethnic groups, but even these change over the years. Fulton (1976) reports that those who minimized their ceremonies of mourning had more depression and anxiety as well as an elevated intake of drugs and alcohol after a year. Cremation has been more commonly associated with serious disturbances among the bereaved than the process of burial and mourning.

Grief and mourning seem to be experienced too briefly in our society; the mourners are urged to return to a state of normality as quickly as possible. It is important to note that mourning, in most cases, lasts for a least a year and that rushing its completion may prolong or burden the entire process. There is evidence to suggest that there is good mental health in the traditional Irish wake or the Jewish shiva. Grief is a necessary reaction to loss and not a sign of weakness or self-indulgence. Funerals and other rituals make death a reality as well as bringing support and warmth to the bereaved (Feifel 1977b).

The grief an individual may feel before the death of a loved one is known as anticipatory grief and may mitigate against the post-mortem grief. People experience grief symptoms about the expected loss and then may have an abbreviated reaction to the actual loss. It appears that some degree of anticipatory grief occurs for all expected losses. Counselors should understand that physical or emotional withdrawal or callous responses may be evidence of anticipatory grief.

The typical features of grief are described in three stages:

- The shock stage, characterized by numbness lasting from a few hours to several weeks
- The second stage, characterized by marked mental anguish, aimlessness, and depression lasting from three to ten weeks.
- The developing awareness stages, followed by recovery where accommodations are made and new relations are established. Recovery is most difficult for older survivors if age means limited new associations, limited opportunities for socialization, and limited new interpersonal relationships.

Survivors are frequently surrounded by their close associates and are emotionally supported by these social contacts. Task-oriented assistance is of great importance since meals must be prepared, shopping tended to, announcements issued, and many other details need immediate attention. These needs are distributed among the support group.

The Support Network

The counselor should be acquainted with the support network of his/her client. Support network is defined as "that set of personal contacts through which the individual maintains his social identity and receives emotional support, material aid and services, information and new social contacts" (Walker, MacBride & Vachov 1977). The network may include friends, relatives, fellow employees, or (for purposes of this discussion) the counselor. The counselor should attempt to help those who have lost the most do the most for the client; only in the absence of resources in the social network should the counselor become a functional part of the network.

Characteristics of a social network most relevant to its serving as a personal support structure are the following (Walker, MacBride & Vachov 1977):

- Size — the number of people in the network
- Strength of ties — the amount of time spent together, the intimacy and emotional intensity
- Density — the extent to which members contact each other independently
- Homogeneity — the extent to which members share common characteristics such as age, sex, and ethnicity as well as attitudinal and behavioral characteristics
- Dispersion — the ease with which members can make face-to-face contact.

Density and homogeneity should increase the likelihood that network members are aware of and discuss the problems of the dying person or survivor. New social contacts are most likely to be established through the strength of the social network and its ties with other networks. Networks may therefore have different value to different individuals, as well as serve different purposes during the entire bereavement period.

Various ethnic groups such as Mexican-Americans, Japanese, Chinese, Native Americans and those Eastern European families with strong group identification (from Poland, Yugoslavia) may have very tight social networks and support systems. It is important that the counselor recognize and use the strengths inherent in such relationships.

The social network is of special importance to the surviving spouse, most frequently the widow. The newly bereaved woman experiences little general tolerance of her grief and has few models to follow. A woman's grief is especially difficult since she is generally an older person in our youth-dominated society; she is single in a couple-oriented society; she is female in a male-dominated society; and she is often poor in a very affluent society (Ball 1977).

The period of widowhood requires a reorganization and reintegration of social roles suitable to a new status, but the process is encumbered by the intensity of her loneliness. Yet some widows are freed by the deaths of their spouses, relieved from the stress of constant care and their focus on the dying spouse.

During the period of intense grief soon after the death of a spouse the most pressing need is usually for empathy and strong emotional support in returning to a normal social life. The responses of the support network will be expected to vary during this process. The support network may not be equally helpful throughout the process and frequently functions most effectively during the early period of bereavement. If the network does not include single persons or does not interlace with other networks the survivor may need to leave the couple-oriented network and find new associations in a single-person network. Such ties can facilitate the transition to the widow role and provide support to the widow's new needs as a single person.

An important new support network for widows are the widow groups or other self-help groups. The widow contact can serve as both a strong, emotionally supportive tie in the early stage of bereavement and later, if necessary, can facilitate the widows' social transition.

Conclusion

The concept of death must be faced by children as well as adults. Unfortunately, it often is camouflaged and denied. If death were less a stranger to us (Feifel 1977a), we could live with the concept as a realistic backdrop that accentuates the importance of life and its experiences. "The full preciousness and uniqueness of life becomes fully available to us only when we understand that death is personal and not just for others" (Feifel 1977b).

Counselors socialized by exposure to negative experiences of death and dying may therefore possess the same values they attempt to overcome. They can be seen as being in a struggle among normative societal values, issues of their own mortality, and their ability to transcend this conflict in a helping role with the dying person and the survivors. To assume that these issues can be comfortably resolved because one possesses counseling skills or has begun to counsel the dying is naive. Through education, counselors should be helped to resolve their own feelings and conflicts regarding life and death. Counselors need direction and guidance in appropriate behavior. Modeling and pattern setting by teachers is an important early step that should follow immediately after the exploration of feelings and values.

Implications for Counselors

Not all counselors can be comfortable or effective in the presence of death and dying. This does not necessarily reflect inadequate counseling skills; it is inherent in this especially sensitive area. It is not the intent of this module to discourage counselors from working with dying patients. On the contrary. But counselors who are unprepared for the traumas of working with the dying are cautioned to get prepared or get out. This is as it should be. Let those counselors comfortable with dying work in this area. Others should avoid these encounters, saving themselves unnecessary trauma. Counselors should not strain their individual resources to exhaustion because of their inability or lack of personal comfort in dealing with death. Yet counselors should be urged to reach the stage of deep compassion or to practice at the highest level of counseling described by Harper.

Counselors should understand that counseling the dying is done by many professionals, support staff members, family, friends, and volunteers. The counselor is challenged to define his/her own unique contributions to this multifaceted team. Counselors are encouraged to depart from the classical one-to-one relationship and to become team builders, environmental manipulators, and patient advocates in addition to being sensitive listeners and helpers. Open communications should be maintained between counselors and other members of the team and between counselors and supervisors. If communication is open and regular, the counselor and team members will know when an individual needs relief from stress.

Counselors who often work with the dying need to become part of a supportive peer group. Such a group need not be limited to counselors; preferably it would include members of the team working together in an institutional setting, home health agency, or community mental health center. Where a support group is not functioning, the counselor should start one, because all members of the team, including the counselor, will need the group and benefit from its activities. Ideally the group should be informal and should attempt to build an accepting environment where each participant could express feelings openly and find understanding among the members. The group should meet regularly and frequently, not only when there is a need.

Because caring is the essence of this counseling relationship, the counselor needs to learn how to confront and cope with the traumas of loss, grief, and bereavement in his/her own life so that the caring can be directed to the client's needs unburdened by the counselor's distractions.

Although counselors need to be available regardless of time when responding to dying persons and their families, counselors also need periods of time away for relaxation and a change of environment. Two weeks a year of vacation are insufficient. Counselors should regularly have times away from work and being on call to re-create, reflect, or do whatever needs to be done to provide a period of detachment from crisis and death.

Counselors can be taught to work with death and dying and can subsequently be teachers for the entire multidisciplinary team. Teaching requires that the counselor first deal with his/her own aging, deterioration, dependency, and mortality and then sensitively assist others to deal with these same issues. The goal then falls into its proper position. The counselor, by performing his/her art and through his/her modeling and teaching, helps people die with greater ease, helps families cope with loss and bereavement, and demonstrates to society that the care of the dying can be model for the humane treatment of people wherever they may be.

Individual/Class Activities

THE SETTING

1. Counselors should visit the setting in which older people are dying, namely hospitals and nursing homes, and observe the rooms, furnishings, and equipment as well as the activities of staff. Observations should include how staff are dressed to identify functions, how their names and roles are identified by identification tags, and how beds and chairs are situated to permit a counselor to interact with the client.
2. A typical patient's chart should be reviewed to understand the organization and function of the chart. The method of charting used in that institution should be understood. The counselor should learn how to read the chart to understand diagnosis and prognosis, treatment program, client's response, and the interactions of all staff involved in the case.
3. Typical members of the care team, namely physician, nurse, and chaplain, should be invited to a class session to describe their function, their perspective on a team approach, and their expectations of a counselor.
4. Where a hospice program is available, arrange a tour of the program or invite members of the hospice staff to the class.
5. Have small groups of students develop a staff training program for death and dying, critique the program, and discuss its implementation.

THE PROCESS

1. Read New Meanings of Death, Feifel 1977a) and Death and Identity (Fulton 1976).
2. Ask each student to recall his/her earliest encounters with death, describe these, and examine how they influenced current attitudes about death.
3. Discuss the ways different ethnic groups handle death and dying in their native cultural setting and in the United States, demonstrating cultural differences, changes, and the impact of American life styles on cultural practices.

THE COUNSELOR

1. Organize class in pairs, instructing each pair to spend five minutes getting acquainted, focusing especially on each person's human qualities rather than job or role.
2. Retaining the same pairs, distribute the discussion guide "How Do You Feel About Death and Dying," instructing students to discuss each question thoroughly. Note whether each member of the pair agrees or disagrees with each statement. Permit 30 minutes for discussion and about 20 minutes for debriefing or feedback about statements they differed with and ideas they could or could not agree with, then encourage large group participation in the discussion. (See Appendix D.)
3. On large sheets of newsprint, ask each student to draw his/her impression of death. Have a large assortment of colored crayons and extra paper available. Advise students that they will be invited to share their drawings with the entire group but that they may choose not to do so. Invite students to share their drawings with the entire group, identifying what death means to them. This should encourage group discussion of the meanings of death and enable each student to appreciate the different meanings.

THE PERSON

1. Show the film How Could I Not Be Among You (rental available through the University of California's Media Center, Berkeley, CA.) A poet is confronted with death from leukemia; the film shows last few months and days of his life.
2. Listen to cassette tapes by Elizabeth Kubler-Ross entitled "The Stages of Dying" and discuss the tapes.
3. Read On Death and Dying by Elizabeth Kubler-Ross.
4. In small groups write a dying person's bill of rights, then critique the contents. (See Appendix C for example.)
5. In small groups stimulate reminiscing sessions, then discuss the contents and value.

THE SURVIVOR

1. Invite funeral directors to class to discuss all the details involved in the funeral arrangements and problems encountered with the survivors.

2. Invite sponsors or members of "widow groups" to class to describe the group's program, response of the participants, and problems of widowhood that make this kind of group valuable to the participants.

3. Invite members of different ethnic groups to describe their ethnic mourning practices and discuss the value of these practices.

4. Have students chart their own social support network, examining the resources available to them during a period of bereavement.

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Audiovisual Aids

Confrontations of Death. 38 min/16mm/color
Vividly records the emotional impact of an existential seminar on death. The film crew were participants in the task-oriented T-groups. Natural settings, natural sound, and natural emotions are shared with the viewer — an unusual experience and a very different film.

Death. 43 min./16mm/1969
The death of a 52-year-old terminal cancer patient, his last days in the hospital, his recollections and regrets about his life, and the responses of his family, doctors, nurses, hospital attendants, clergy, and other patients are depicted in the film.

What Man Shall Live and not See Death. 57 min./16mm/color/1971
Examines, through research, seminars on death, and interviews with the dying and the bereaved attitudes and problems connected with the way Western society has encouraged our dealing with death and bereavement. Partial content: research of Dr. Elizabeth Kubler-Ross, St. Christopher's Hospice for the Terminally Ill, cryonic preservation of bodies.

Understanding Death Series. Four color and sound filmstrips: "Life/Death," "Exploring the Cemetery," "A Taste of Blackberries," and "Children and Death."

Death and Dying: 3 sound filmstrips, with discussion guide and either 3 12-inch LPs or cassettes.
Includes:
"The Meaning of Death" — Psychological responses.
"A Time to Mourn/To Choose," — Death rites here and abroad.
"Walking in the World for Me" — Doris Lund discusses her son Eric's struggle against leukemia.

Perspectives on Death. Filmstrips and 2 cassettes and 4 books: Funeral Customs around the World, Death Through the Eyes of the Artist, Death Themes in Music, and The Individual, Society and Death. Also includes Teacher's Resource Book and Student Activity Book.

Working with Death Series. A four-unit series in color and sound for training professionals and counseling patients. Includes: "Death & the Doctor," "The Dying Patient," "The Family," "For the Terminal Patient," and "Living with Dying." User's guide included.

Facing Death. 20 min./16mm/color/1968
Discusses the psychological problems confronting the physician when s/he must inform the patient and family of a terminal condition. Stresses individual rapport and the necessity for understanding patient's reaction to stress. For restricted viewing only. Produced by Council for Interdisciplinary Communication in Medicine under a grant from Pfizer Laboratories. Contact NBC Studios, Burbank, California.

Widows. 43 min./16mm/color
Several women describe their experiences after the deaths of their husbands. Their frank and touching comments demonstrate some of the stresses of widowhood and suggest various strategies for preventive intervention on behalf of widows and of their young children. The film aims to help the viewer understand the needs of this group and to encourage discussion of appropriate action.

Will Drafting. 40 min./16mm/B&W
This film demonstrates the solution-oriented interview technique of will drafting. The attorney's two clients differ radically in age, social background, and financial circumstances. One is a young man, with a wife, young children, and a small estate. The other client is an older man who has grown children and a large estate. Produced by University of California Extension Media Center.

Journey's End. 28 min./16mm/color/1974
This film stresses the importance of making essential preparations for death. The film is intended to encourage long-range planning for death by the preparation of wills, acquiring a knowledge

of probate procedures and in specifying funeral arrangements. A film guide is available to assist group discussion. Produced by Perrow Productions.

Death, Grief and Bereavement. 24 cassette tapes.
Discussions on a wide range of thanatological topics by outstanding leaders in the field including Elizabeth Kubler-Ross, Robert Fulton, and Cecily Saunders.

University of Minnesota
Center of Death Education and Research
1167 Social Science Bldg.
Minneapolis, Minn. 55455
Audiocassettes including "Dialogue on Death," "Stages of Dying," "Social Reconstruction After Death," and "The Meaning of Death in American Society."

Evaluation and Assessment

1. Discuss the experience of losing control over one's life when one has been informed of his/her impending death. What can the counselor do to help put the dying person back in control of his/her life?

2. Discuss the differences between the sick role and the dying role. What are the advantages and disadvantages (as delineated by Parsons) of both? How may the counselor's role differ in interacting with these two kinds of clients and their families?

3. Within the institutional environment who are the counselor's potential clients? Discuss the relationship the counselor may have with each of the individuals you describe.

4. Hospice care has revealed that there are several key issues in the holistic care of the dying that pertain directly to counseling. What have we learned from the hospice movement that is applicable to counseling the dying?

5. Characterize the current ethos of death and dying in American society according to Feifel. What are the implications of these characteristics for counselors of the dying?

6. Briefly describe some potential problems of territoriality in an institutional environment where the counselor of the dying patient (the newcomer) enters the existing team of caretakers. How can the counselor most quickly resolve some of these issues to facilitate the establishment of an effective supportive relationship with the dying person without alienating the staff? Are there times when the counselor should not intervene for the benefit of the client?

7. Before a counselor sees a potential client (the dying person) what are some things that s/he should know about the environment? about the patient's caretakers? What are some observations about the client's support system that the counselor should make after accepting a client? about the patient's room? about the client's affect? Discuss these briefly.

8. Briefly discuss the emotion experienced and possible behavior demonstrated in the stages of Harper's "line of comfort-ability," which discusses coping with professional anxiety in dealing with terminal illness:

Stage I — intellectualization
Stage II — emotional survival
Stage III — depression
Stage IV — emotional arrival
Stage V — deep compassion

Do you agree with her conclusions?

9. Discuss the relationship between bereavement, grief, and mourning. What are some cultural practices that may impede or facilitate the grieving process?

10. What is the importance of a social network for a dying person? Discuss the characteristics of a social network that may make it most beneficial in serving as a personal support structure?

APPENDIX A

Training Model #1

While the specific content or procedures for the educational program may vary with the time allocated, the setting, staff participating, and expertise of the counselor, one model that has been tried and demonstrated effective is suggested here. This training program was organized into three distinct but interrelated parts, extending from three to four weeks. The first part, offered in two days or 16 hours of instruction, provides background material about death in our society, discusses the mental health concepts in death, dying, and grieving, explores the care of the dying person and introduces some opportunities for the participants to reflect on their own lives, aging process, and death.

Small group and interactive sessions are limited to about eight persons, each with a group leader, so that ample opportunity is provided for the exploration of feelings and interactions of the participants. The materials explored during the 16 hours progresses from the didactic and descriptive to personal responses to death and care of the dying.

The length of time is important to bring people into the process regardless of their educational background or personal experience with dying. A level of trust and comfort should be established during this period so that participants are reasonably comfortable with the expectations of the second phase of the program.

At the conclusion of the 16 hours, every member of the training group is given an assignment to visit, talk with, and observe a dying person, his/her significant others and individuals within the environment in which the person is dying. Two weeks later participants return for another day for debriefing. Their observations are discussed and assimilated for use as teaching tools by participants in their practices.

The training program is designed to present factual information in combination with experiential learning. It was anticipated that such a combination would be useful to each participant in the care of dying persons, in helping other staff gain in their sensitivity, and to alter and improve the institutional response to the dying person.

In a follow-up mail questionnaire two months after the training program, participants in the pilot program reported awareness of greater sensitivity to the needs of the dying patients and greater ease in responding to the dying person (Koff 1976). In a comparable study, Watts (1977) reported that "favorable death attitude change can be achieved using a relatively brief death education unit within an introductory health education course" in a university setting.

Training Model #2

In response to the needs of staff members caring for terminally ill patients at the Houston Veterans Administration Hospital, a one-day workshop was developed. The format encompassed a didactic as well as an experiential approach. The workshop leaders met with staff members in the morning and staff were encouraged to share their goals, experiences, and hopes for the workshop. Interaction between staff and workshop leaders took place in a comfortable and informal atmosphere.

The second portion of the workshop consisted of the presentation of a "disaster fantasy." Instructions were given to the participants and the total group was then divided into smaller groups. Each group had to deal with the given situation and help one another die with dignity. The exercise was valuable in stimulating participants to examine personal feelings about death. There was a limited time alloted to deal with the disaster. This helped do away with superficial and guarded responses. Another major key was the participants' willingness to accept the fantasy.

Whatever kind of training program is developed, it seems essential to include some background information on dying, opportunities for participants to increase their insights into their personal responses to dying and death, some time to respond to new stimuli, and opportunities for sharing new experiences. Although additional research is necessary to support both the value of education and the specific content essential to the educational program, preliminary responses suggest that educational programs are helpful to health care, providing that the counselor-directed educational program can constructively promote the role of the counselor as a helper for staff as well as for patients.

APPENDIX B

Case Illustration

One example of the way in which a counselor functions is illustrated below:

A family service agency counselor who had been regularly visiting an elderly patient in a nursing home learned that Annie, her client, was expected to die very soon. When the counselor visited Annie it was clear that she was not fully aware of the severity of her condition, although she had deteriorated appreciably. Annie was confused about her medical status and was receiving little accurate information from her physician or the nursing staff. Her belongings had already been packed in cardboard boxes in expectation of her death. Her family and friends had not been notified about the gravity of the situation.

With Annie's permission and encouragement, her counselor called the physician, who had known his patient for many years, and requested that he visit with Annie. He promptly came and expressed to Annie and the counselor his own sad feelings about the impending loss of his friend and patient. The counselor called Annie's best friend, her younger brother, and her niece to tell them Annie was dying.

During the next few hours, all three came to see Annie for the last time. None of them felt comfortable staying more than a few minutes. The nursing staff was willing to allow the counselor as much time as she needed and she decided to stay with Annie throughout the night. They spoke at length and Annie revealed that she was aware of her situation because of the discussion with her doctor and the counselor. She indicated that she felt far better now that the ambiguity of her condition had been reduced. She was able to say goodbye to several of the people most important to her. Later that evening, with the counselor by her bedside, Annie died.

APPENDIX C

The Dying Person's Bill of Rights

I have the right to be treated as a living human being until I die.

I have the right to maintain a sense of hopefulness however changing its focus may be.

I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this might be.

I have the right to express my feelings and emotions about my approaching death in my own way.

I have the right to participate in decisions concerning my care.

I have the right to expect continuing medical and nursing attention even though "cure" goals must be changed to "comfort" goals.

I have the right not to die alone.

I have the right to be free from pain.

I have the right to have my questions answered honestly.

I have the right not to be deceived.

I have the right to have help from and for my family in accepting my death.

I have the right to die in peace and dignity.

I have the right to retain my individuality and not be judged for my decisions which may be contrary to beliefs of others.

I have the right to discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others.

I have the right to expect that the sanctity of the human body will be respected after death.

I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

(American Journal of Nursing, 1975, 75, p. 99)

This Bill of Rights was created at a workshop on "The Terminally Ill Patient and the Helping Person," in Lansing, Michigan, sponsored by the Southwestern Michigan Inservice Education Council and conducted by Amelia J. Barbus, associate professor of nursing, Wayne State University, Detroit.

APPENDIX D

How Do You Feel About Death and Dying? A Discussion Guide

Please respond to the following questions using the following key:

1 = strongly agree
2 = agree
3 = disagree
4 = strongly disagree

_______ 1. Everybody fears death.
_______ 2. Patients should be allowed to die without resuscitation measures.
_______ 3. Death is the end of all life.
_______ 4. People shouldn't have to die alone.
_______ 5. Every patient has a right to know that he is dying.
_______ 6. God wills death.
_______ 7. Euthanasia is appropriate under certain circumstances.
_______ 8. My first experience with death was (will be) very painful.
_______ 9. Patients should be allowed to go through the stages of death.
_______ 10. Death is an end to suffering.
_______ 11. I feel guilty when patients die.
_______ 12. Counselors should let patients introduce the topic of death.
_______ 13. "When it's your time to go, it's time to go—other than that I just don't think about it."
_______ 14. All suffering has meaning.
_______ 15. "Modern medicine is devoted to the preservation of life and death is viewed as an intrusion into a scientific quest for eternal existence."
_______ 16. Touch is very important to the dying patient.
_______ 17. Death is a part of the balance of the universe.
_______ 18. I fear death for my loved ones.
_______ 19. I fear death.
_______ 20. Counselors should not allow patients and families to see them cry.
_______ 21. The stages of dying can be found in every death.
_______ 22. Life exists after death in another form.
_______ 23. Part of the fear of dying is fear of loss of self-control.
_______ 24. Deep religious convictions are necessary for a "healthy" dying.
_______ 25. "Death is the only certainty in life."

MODULE VI

ELDERLY NON-WHITES: UNIQUE SITUATIONS AND CONCERNS

Clemmie Solomon

Clemmie Solomon is the Director of Counseling at Bowie State College, Bowie, Maryland. He has been active as a consultant to numerous projects on gerontological programming with emphasis on youth attitudes towards the elderly and counseling elderly minority groups. In 1977, he testified as an expert for the American Personnel and Guidance Association before the U.S. House of Representatives Select Committee on Aging regarding counseling elderly Americans. He serves as a member in several capacities on numerous national organizations and interest groups whose focus is on serving the elderly. Some of these include the APGA Advisory Committee on Aging, the National Caucus on the Black Aged, and the Congressional Black Caucus Braintrust on Aging. In addition, he serves as chairman of the APGA Government Relations Committee.

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INTRODUCTION
Statement of Congressman Harold Ford

Minority elderly are a people of great stamina. They have had to overcome the insurmountable barriers of poverty, discrimination, language and cultural barriers, etc., just to reach what should be the rewards of old age. They have found that the multiple hazards of age and race have led to the compounded problems of inadequate income, poor housing, insufficient health care, high mortality, and lack of necessary social services. Even as these services are made available by Congressional, Federal and State action, minority elderly are the least informed of such available services and are, therefore, usually the least likely served. The need, then, clearly exists for counseling services to be made available to minority elderly to help bring the quality of their lives up to that of the majority of Older Americans.

As a member of the House Select Committee on Aging, I am acutely aware of the needs of the elderly population of the Nation. As Chairman of the Congressional Black Caucus Subcommittee on the Aged, I realize how the special needs of minority elderly have been ignored from the federal sector down to the local level. We owe minority seniors who have little else to depend on a comfortable income through the Social Security system. We owe them adequate health care including ample nursing home care where needed. We must assure them the use of Multipurpose Senior Centers by making the centers available within their own communities and by allowing them access to public transportation. Most of all, we must hear their case and address each need as thoroughly as we would that of any American citizen. Through counseling, we receive an exchange neccessary for the good of all America by allowing potentially productive citizens the opportunity to live their lives to the fullest.

ELDERLY NON-WHITES: UNIQUE SITUATIONS AND CONCERNS

Rationale and Objectives

Current data on elderly non-whites suggests that this diverse and wide-ranging population is not only a victim of ageism, but they are more consistently subjected to double and triple jeopardy (Kent 1971; Mosley 1977): The effects of historic racial discrimination, lack of opportunity, and mental and physical oppression of this population warrant a greater understanding of the factors that compound their unique situation and concerns.

The counselor, in order to acquire the skills to be successful in counseling elderly non-whites, should be cognizant of their uniqueness. This prerequisite is essential to understanding elderly non-whites and should prove beneficial in facilitating counselor effectiveness. As the field of counseling matures to deliver helping services to all Americans, it becomes imperative that counselors possess the necessary competencies and abilities to render services to a heterogeneous clientele. The counselor who can exhibit such versatility in the counseling profession will probably become a greater help to elderly non-whites and become more resourceful and competent as well.

A focus on the special problems of elderly minority groups developed from four special concerns sessions at the White House Conference on Aging (1971). The four minority groups represented at the conference (those presented in this module) were elderly Asian-Americans, Indians, Blacks, and Hispanic-Americans. Each group expressed their concern and need for mental health services. The U.S. Senate Special Committee on Aging (1976) noted additional concerns that emerged from the four White House sessions, despite cultural and other differences of elderly non-whites. All of the minority elderly groups agreed that the minority elderly suffer greater deprivation than older Anglos. There was widespread agreement that far too little attention has been devoted to the special needs of the minority elderly.

The groups emphasized the need to develop more accurate and complete data to enable policymakers to make key decisions on issues affecting elderly non-whites. They also expressed the importance of developing and conducting training programs for those working with elderly minorities. Requests for research and training are congruent with the obvious counseling needs of the minority elderly. The need for this module is affirmed by the letter and spirit of Title VI of the Civil Rights Act of 1964, which states that:

> No person in the United States will, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The objectives of this module are as follows:

1) To present relevant data about the status and concerns of non-white elderly groups

2) To increase the level of counselor awareness of the non-white elderly

3) To apprise counselors of the considerations, implications, and strategies of counseling elderly non-whites.

Certain considerations and limitations of this module should be noted. First, the module is limited to four minority groups. They include Blacks, Hispanic-Americans, Indian and Asian-Americans. This is not to suggest that these are the only elderly minority groups; however, questions of ethnicity, scarcity of information, and the ambiguity of defining minority status cloud the determination and treatment of other groups. Second, counselors are reminded that the four groups presented here are each distinctly different. Generalizations across cultures should be made carefully. Third, differences abound even within each group. For example, there are over 500 American Indian tribes in the United States. Geographical location, customs, and language are just a few of the differences among Native Americans. A similar consideration exists with Asian-Americans and Hispanic-Americans. And just as differences exist between Chinese and Japanese cultures, they are also prevalent between Mexican- and Puerto Rican Americans.

Fourth, it should be noted that the terms used to identify each ethnic group are occasionally interchanged.

Finally, it is recommended that a review of Module I on demographics precede the study of this module.

THE BLACK ELDERLY

The plight of the Black elderly has often been described in terms of their undergoing multiple jeopardy from a combination of problems caused by racism, ageism, poverty, and, for women, sexism. Lindsay and Hawkins (1974) note that, "An anonymous person once said, 'I don't mind being old, or Black, or even poor, but I'll be damned if I want to be old, Black, and poor at the same time'." Such is the case for the majority of America's Black elderly. Poverty stifles their enjoyment of the later years.

U.S. Department of Health, Education and Welfare (1976) figures indicate that the proportion of the population over 65 years old was 11 percent for whites, compared to 7 percent for Blacks. The Administration on Aging (1971) reported that a shorter life expectancy for Blacks produces a smaller proportion of older Black persons. About 15.7 percent of the general population, or 3.3 million persons, were below the poverty level in 1971. Among elderly whites, one in every seven was poor while over one third of elderly Blacks were below the poverty level. Mosley (1977) discovered that 32 percent of Black men and more than 40 percent of Black women 65 or older are in the low-income category.

A statement by the National Caucus on the Black Aged (1977) emphasized the poverty of the Black elderly. It noted the existence in America today of a generation of Black people who are too old to work, too undereducated to qualify for work, and who, during their productive years, were relegated to menial and low-paying jobs. The statement continued, "This gives them, in their twilight years, the lowest of the low income-related retirement incomes and benefits."

Consistent with other reports of the poverty affecting elderly Blacks are the findings of the 1974 Michigan Comprehensive Plan on Aging (Policy Program Analysis Division 1975). Through Title IV funding, the University of Michigan and Wayne State University conducted a survey of elderly Michigan residents to identify the major problems with which they were confronted. Elderly Blacks listed their five major difficulties, in descending order, as: income, health, crime, nutrition and transportation (tied), and housing. Nearly two out of three elderly Blacks (68%) identified income as a serious problem. In contrast, 35 percent of elderly whites considered income to be a major problem. The tragedy for all the elderly poor is the permanence of their poverty. Having passed their prime earning years, they have no expectations such as those of poor students and young couples who may be temporarily poor, for an increased income in the future.

There are other problems besides poverty. As Lindsay and Hawkins (1973) pointed out, for the Black elderly the most basic problems of income, maintenance, and housing are reflected in poor nutrition, poor physical and mental health, increased vulnerability, and high mortality. They further stated that even in the area of social relationships, which have provided a haven for many Black elderly, we still find pockets of elderly Blacks in geriatric ghettos who live out their lives in loneliness and isolation. Despite the hardships and disadvantages imposed on the Black elderly, they have shown remarkable strength and resilience in the face of adversity. Special strengths of Black families that are particularly important to the Black elderly are the adaptability of roles, strong kinship ties, strong religious orientation, strong work orientation, and strong achievement orientation.

At the White House Conference on Aging (1971), the special concerns session on the Black elderly identified several concerns and recommendations. First, priority should be given to establishing a system providing at least a moderate guaranteed income for all Black elderly. In listing their most critical needs, most Black elderly cite income before all others. Other areas of concern include physical and mental health, employment, retirement, nursing homes, education, housing and transportation. Recommendations include establishing community health corporations for comprehensive health service delivery, instituting new trends in long-term care, reducing barriers to nursing homes for the Black elderly, and increasing the recruitment of Black health professionals in all areas of physical and mental health.

At the Congressional Black Caucus legislative workshops (1977) several additional recommendations addressing the needs of the minority elderly were made:

1. Support welfare reform and work to avoid abuse of the programs.
2. Enforce specific target areas for program sites to increase minority participation.
3. Include elderly minorities in planning state nutrition programs.
4. Increase minority participation in housing programs.
5. Include eyeglasses and dentures under Medicaid.

THE ASIAN-AMERICAN ELDERLY

Elderly Asian-Americans consist of Chinese, Japanese, Filipinos, Hawaiians, East Indians, Koreans, Thais, Vietnamese, Burmese, Indonesians, Laotians, Malaysians, Cambodians, and Samoans. For the purpose of this module, however, the primary focus will be on the elderly Chinese- and Japanese-Americans. Like other minority elderly, the Asian-American elderly are victims of multiple jeopardy — ageism, institutional racism, poverty, declining physical health, and inadequate housing. Compounding these problems are language and cultural differences and a fear and distrust of nonethnic agencies and institutions (Fujii 1976). Asian-Americans, just as other minority groups, should not be treated as a homogeneous group.

Large numbers of today's elderly Asian-Americans are immigrants and have encountered racial discrimination and economic exploitation. The special concerns session on elderly Asian-Americans during the White House Conference on Aging reported that most Asian-Americans are foreign-born and after migration generally continue to follow their own cultural patterns and practices. Specific concerns presented at the session were the following:

1. Cultural barriers exclude Asian-Americans from receiving their rightful benefits.
2. Language problems due to a lack of bilingual service workers deny them knowledge of how to obtain services.
3. Most importantly, the Asian-American elderly are severely handicapped by the misconceptions that pervade society and permeate policymaking agencies and government organizations.

The myth in question is that elderly Asian-Americans have no problems, are capable of taking care of their own, and do not need or desire help in any form. Several writers (Kagiwada & Fujimoto 1973; Sue & Sue 1973) have refuted these assertions. Fujii (1976) noted that the suicide rate for the Asian-American elderly in certain areas is three times the national average. Thirty-four percent (34%) of the Asian-American elderly studied have never had a medical or dental examination. Nutrition programs for older people who receive federal dollars fail to include the special dietary and cultural preferences of older Asian-Americans.

An understanding of the needs of the Chinese-American elderly can best be obtained by a look at their culture. For example, filial piety is a very important virtue in the Chinese value system. This means to respect, love, obey, and support one's parents in time of need. Chinese culture emphasizes kinship from birth to death so that needs tend to be obtained at the price of conformity to family and elders (Sue 1977).

Chinese people are also very realistic about life cycles. They are very aware that old age means that their energy will decline, their life will be limited, and their ability to support themselves will be difficult. Therefore, Chinese culture has a built-in compensatory device whereby the elderly enjoy later life through the support of their children. In recent years this family structure has begun to change.

The influence of the American value system and social structure has swayed younger generations of Chinese-Americans from traditional family practices and customs. The virtue of filial piety has weakened. There is a developing tendency to believe that if a person is old, he cannot work and earn money and therefore is deemed useless. The younger generation is not as compelled to support their elderly; thus the Chinese elderly are faced with increasing disappointment and disillusionment (Chang 1977). Some maladjustments of the Chinese elderly are traceable to their lack of material success in America and their inability to return to their homeland.

Current literature on Asian-Americans debates the assertion that they are a "model minority," a prime example of acculturation, assimilation, and success in modern American society. This is the picture often painted of the Japanese-American. For example, the Issei, most of whom are elderly, are first-generation Japanese-Americans. The majority of them are economically secure. Most reside with or in close proximity to their children and participate in church and Issei organizations in the community. The Nisei sons, or second-generation Japanese-Americans, derive status in the community from taking good care of their widowed mothers. There is a growing concern, however, that traditional customs and values clash with the dominant American values.

Fujii (1976) mentions that many of today's Japanese elderly remember the trauma of incarceration in American concentration camps during World War II. The internment forced many Japanese-Americans who operated small businesses before their incarceration to liquidate them. After the war, many returned to laboring and servant jobs since they no longer had their businesses. This financially and psychologically devastating experience convinced many that the land of opportunity was not meant for those of Asian ancestry. Japanese-Americans who were incarcerated are now eligible for Social Security wage credit for time spent in the camps; many are not taking advantage of this benefit and are probably unaware that they can claim it.

The contention that Chinatowns are ghettos in the true sense of the word is supported by Suzuki (1975). They are segregated, overcrowded, and impoverished. The misconception that Chinatowns are gay, exotic, romantic, and colorful places where their inhabitants choose to live is not substantiated. In San Francisco, for example, over 20 percent (approximately 10,000) of Chinatown's population is over 65; nearly 90 percent of these are living in extreme poverty. Many residents have been found living on $25 to $60 a month, severely ill, and unable to get medical aid. Many are unaware of the health facilities and old-age pensions available to them.

Sue (1977) contends that the incidence of poverty for elderly Asian-Americans is much higher than that for elderly Blacks and Hispanic-Americans. He asserts that the rate of mental disorders among this group has been underestimated. Sue's observations on "learned helplessness" are noteworthy; learned helplessness results from previous experiences with noncontrollability, i.e., where outcomes are independent of action. Historically, Asian-American immigrants were not allowed to vote, testify in court, and participate equally in American society. This inability to control their destiny fostered a sense of learned helplessness.

Kim (1973) reminds us that the myth that Asian-Americans are a homogeneous model minority ignores the many problems their heterogeneous communities face. He concludes, "Behind the busy, prosperous shops and restaurants of Chinatown and Little Tokyo are thousands of unattended old people wasting away their remaining years in poverty and ill health" (p. 44).

HISPANIC-AMERICANS

The Hispanic-American elderly include those of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish background. This module, however, will deal primarily with those of Mexican and Puerto Rican ancestry. Little information on those of Cuban and Central or South American descent is available. Moore (1971) reports that the general population of Mexican-Americans have so many serious problems that the difficulties of the Mexican-American elderly have received little attention.

Only 4 percent of the Hispanic-American population is 65 or over. They are particularly vulnerable because of language and cultural barriers, physical isolation, and the disadvantages endemic to minority status. For example, two handicaps encountered by Hispanic-American elderly in American society are their inability to speak English and their lack of understanding of the system. There seems to be a high correlation between the ability to speak English and an awareness of services, activities, and programs to which the Hispanic-American elderly are entitled. Issues generated in the special concerns sessions of the White House Conference on Aging provide a more global picture of this group's needs. Income, as for most minority elderly, leads the list. Many Hispanic-American elderly have experienced life-long poverty and therefore have been unable to save toward retirement or secure adequate pension and Social Security benefits. Many receive no public assistance and depend on help from friends and family.

Concerning health, the Hispanic-American elderly have above average mortality rates. At age 48, a Hispanic-American migrant's health compares with that of an Anglo of 65. Medicare and Medicaid provide relief but are considered inadequate to meet needs. Transportation in rural areas is considered too expensive and is usually unavailable. In metropolitan areas public transportation is too expensive and communicating with bus drivers and understanding routes and schedules are often difficult. Inadequate nutrition affects many of the poor Hispanic-American elderly. The initial cost of obtaining food stamps makes their acquisition prohibitive for many poor Hispanic-American elderly.

There is a need for innovative employment programs that would allow opportunities for jobs without penalizing retirement or other benefits. Many Hispanic-American elderly who own their own homes, often lack regular facilities such as hot water, proper electrical wiring, and decent heating systems.

Several recommendations were made at the White House Conference. Public transit systems should provide discount fares or free fares during nonpeak hours. Schedules and routes should be printed in Spanish. Recruitment of bilingual, bicultural students for health professions and geriatrics should be given special consideration. The Hispanic-American elderly should be represented on commissions, councils, and committees concerned with planning, operating, and evaluating comprehensive health service systems funded by federal, state, and local government. The establishment of a minimum guaranteed income, federal funding for home improvement, and federal housing designed with Spanish culture in mind was recommended. In addition to the aforementioned concerns and recommendations, it is noteworthy to address some concerns of the Puerto Rican Elderly Caucus at the National Conference on the Black Elderly (1971) in Washington, D.C. The Puerto Rican participants supported and endorsed the concerns of all older people of minority groups, such as income, health, housing, and transportation. The group called for greater representation and input regarding government funded programs; establishment of Central Spanish Speaking Agencies with multi-service delivery systems in U.S. cities; and that fully trained bilingual professionals be assigned to agencies, especially those in areas with high concentrations of Spanish-speaking people.

In lieu of the use of traditional psychological services, a system that combines family, curanderos (folk healers), and the church may be at work in Mexican-American culture. When this system fails, alcoholism and similar problems may arise rather than classic psychotic symptoms. Additional reasons for the underutilization of mental health institutions by the Mexican-American elderly include: (a) geographic inaccessibility, (b) problems in communicating with professional staff, (c) inaccurate diagnoses based on middle-class values, (d) the social distance between health professionals and Mexican-Americans, (e) reliance on the traditional physical symptoms model of inquiry, which does not consider potentially significant ethnographic data, and (f) prejudice.

On the treatment for psychosis, Bell, Kasschau, and Zellman (1976) found a much lower incidence of treatment for psychosis for Mexican-Americans: 42/100,000 compared to 80/100,000 for Anglos. The same study, however, reported that a look at Mexican-American and Anglo admissions to state mental hospitals in Colorado found a high rate for Mexican-American males. This data may prove misleading since state mental institutions are often used as poorhouses, jails, and drunk tanks for low-income persons. What is significant is the indication that the Mexican-American population is subject to high stress indicators so that they are likely to have a greater need for mental health services than the average person.

THE INDIAN ELDERLY

Elderly Indians live in three types of environmental settings: urban, rural, and reservations. On virtually all indexes of social status (income, education, health, and employment) the Indian is below all other groups. The average age at death for the Indian is dramatically lower than that for all other ethnic groups due largely to a lack of decent housing, poor nutrition, inadequate transportation systems, insufficient medical services, and poor communications systems (Essandoh 1977). The average life expectancy for all Indians is 46 years. The absence of adequate education, counseling, and job training, combined with discrimination, has been attributed as the cause of over 70 percent of the unemployment found in most Indian communities.

Blake and Peterson stated in Module 1 that "their extreme economic and health problems and their short life expectancy suggest the possible need to alter guidelines by which some service programs operate" (p. 20). For example, in Montana's state plan for the elderly, authority was granted under the Older Americans Act, Titles III and IV, to consider Indian Americans "old" at age 45 in recognition of the social facts of the Montana Indians' condition (Montana United Indian Association 1976).

Elderly Indians would prefer to have an income that would permit them to live the rest of their lives in good health, decency, and dignity. Yet many Indians' sole source of income is welfare; for those fortunate enough to reach the eligibility age, Social Security is at the very minimum level. Among other concerns presented at the White House Conference on Aging were insufficient income, inadequate legal services, lack of nursing homes or sheltered care facilities (some states refuse to license nursing homes on reservations), poor transportation, and deplorable health conditions. Lack of funds for dental prostheses, hearing aids, eyeglasses, and psychological services were also concerns. Many elderly Indians seek medical attention primarily when the illness has reached the crisis stage; thus, preventive health care is almost nonexistent.

Several writers (Dozier 1966; Ferguson 1968; Levitan & Hetrick 1971) point to the high incidence of alcoholism among Indians. Graves (1971) indicates that excessive drinking by the inhabitants occurs in most Indian communities. Dunn (1975) focuses on the history of alcohol in Indian culture. The misconception that all Indians are alcoholics should be negated by counselors and efforts to address the alcohol problem where it does in fact exist should be made.

Bell, Kasschau, and Zellman (1976) report that identifying Indians eligible for services is sometimes a problem. The Bureau of Indian Affairs (BIA) is the federal agency responsible for reservations and Indians who live near reservations. An Indian, according to the BIA is a person who has more than one-fourth Indian blood. To be eligible for services, such as free medical aid, under BIA authority one must meet this criteria. This often poses problems, for example, in Texas, many Indians are frequently assumed to be Chicano because of their Spanish surnames.

Graves and Van Arsdale (1966) note Indian relocation from the reservation to urban areas. This migration suggests that elderly Indians who lose BIA benefits because they have left the reservation may require assistance in adjusting to their new environment. The economic dependence of the elderly on younger wage earners often necessitates the elderly Indians' moving with the family to the city. The social characteristics of the Indian, suggesting strong family solidarity, are evident in the nuclear family, as well as the extended family, the clan, and the tribe. There appears to be a tendency for

Indians to fraternize with their own tribal group. Communal sharing is very prevalent. These factors may not necessarily be indigenous to Indian culture; it may be a situational reaction to an environment that is perceived as being hostile, insensitive, and unresponsive to Indian needs.

In a specific example, two factors emerge when attempting to understand the role of elderly Montana Indians. First, councils of elders were often the active centers of tribal decision making and authority. Today's older Indians remember the prominence of the elderly in reservation government and politics. Passage of the Wheeler-Howard Act in the mid-1930s reorganized the councils to reflect democratically elected governing bodies. The traditional decision-making roles of the elders were diluted. Second, the elderly Indian played an exclusive role in transmitting the values, traditions, and cultural heritage of the Northern Plains Indian. Because they lacked a written tradition, the older Plains Indians transmitted the entire history, language, art, and value system to younger generations (Montana United Indian Association & Committee for the Humanities 1976).

Concerns presented by the elderly Indians at the Montana Indian Conference on Aging were inadequate representation on tribal councils, an unemployment level as high as 70 percent that never gets lower than 40 percent, and unequal access to medical help for psychological problems. Conference participants generally agreed on the following:

1. The retention of self-esteem and the ability and privilege to do meaningful work are important to elderly Indians. The former may be achieved by the realization of the latter.
2. The stresses of living in a dual culture decreases resistance to the erosions of age.
3. The reduced role of the elderly Indian is due to the breakdown of extended family relationships.
4. Unemployment, although greatest on the reservation, is high for non-reservation Indians also.
5. Preventive medicine should be used to avert outside pressures and stresses before they produce physical problems.
6. Research to determine the differences in stress levels between reservation life and off-reservation life is necessary.
7. Efforts should be made to get the government to lower the eligibility age for all programs for the elderly to 45 for Indians.

The first National Indian Conference on Aging (1976), representing 171 tribes, identified several similar concerns. The needs in the area of mental health include:

1. Funding to finance well-rounded social or culturally oriented activities for elderly American Indians
2. Acquisition of programs to address the needs of lonely and depressed elderly Indians
3. Social services with greater Indian staff representation
4. Development of programs to train Indian staff to provide service delivery
5. Staffing programs with Indians in order to address the alcoholism problem

Implications for Counselors

The delivery of counseling services to the elderly is problematic at best. Many of the American elderly spend the final years of their lives in environments characterized by inadequate income, inferior housing, and a lack of medical care and other needed services. As indicated in the preceding section, the outlook is particularly dismal for elderly members of ethnic and cultural minority groups. For most of these individuals, the factors that contribute to a lifetime of economic and psychological struggle are exacerbated in old age. Some of these factors seem to severely affect counseling services delivery to the minority elderly and are common to each group in varying degrees: (a) multiple discrimination, (b) cultural factors, (c) communication and language barriers, (d) differences in socioeconomic status, (e) problems of physical and financial access to services (f) differences in eligibility for services, and (g) insufficient minority counselor representation.

Multiple Discrimination

The U.S. Commission on Civil Rights Study on Age Discrimination (1977) emphasizes that: "Members of minority groups, women, and handicapped individuals are victims of compounded discrimination based on age, sex, race, national origin, and handicaps."

The impact of this multiple discrimination is further documented in the same study by the Group for the Advancement of Psychiatry.

> Being Black and aged frequently means the piling up of life problems associated with each characteristic. The Black aged often have less education, less income, smaller or no social security income, less adequate medical services, and fewer family supports than the aged

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in general; their vulnerability is often heightened by their living in areas where the risk of assault and robbery is high. Racism and "ageism" may be combined to prevent the Black aged from getting needed services of all types.

Although the second statement addresses the Black elderly specifically, evidence presented in the preceding section suggests its applicability to each of the minority groups discussed here. Multiple discrimination alone is capable of permeating and affecting all the other factors. Therefore, counselors should be cognizant of its magnitude and work toward its extinction in American society.

Cultural Factors

Historical and cultural differences among ethnic groups may represent possible sources of difference in the degree to which counseling services and service delivery methods will be accepted and used by elderly non-whites. Culturally established differences in expectations and norms may have significant implications for the manner in which counselors interact with clients.

For example, suggestions that elderly Mexican-Americans seek health care from folk healers and that Chinese seek care from herbalists have been made. This may not be solely because of cultural reasons; it may also be due in large part to the insensitivity toward elderly non-whites displayed by the staffs of traditional service delivery systems.

Communication and Language Barriers

Communication is an essential and integral part of counseling. Obviously, counseling can be best provided when counselor and client speak the same language. Many elderly members of the Asian-, Mexican-, and Native-American communities are unable to understand and/or communicate in English. Some elderly Blacks experience a similar barrier, especially in certain areas of the rural South. Elderly non-whites may be unaware of social services for this reason alone. Furthermore, fear of difficulties in communication may cause elderly non-whites to seek service providers in their own communities, especially when ethnic prejudice combines with the potential embarassment of language difficulty. Certainly, there is a case for bilingual counselors.

Differences in Socio-Economic Status

There are significant differences in the socioeconomic status of the ethnic groups represented in this module. For example, as reported in the module on demographics, in 1970 the median income for elderly Indians was only $1,654 for males and $1,162 for females. The median income during the same period for elderly Asian-Americans varied from a high of $2,528 for elderly Filipino males to a low of $1,943 for elderly Chinese males. Japanese women ranked highest among the older Asian-American female population at $1,312 and Filipino women ranked lowest at $1,130.

The various Asian-American groups often point to a higher incidence of social and economic distress suffered by their members. This often serves as a justification for increased attention to their social service needs by decision makers in public agencies. Virtually all the groups, in varying degrees, undergo lifetimes of discrimination and impoverishment and these hardships multiply to impose increased hardship in old age. Bell, Kasschau, and Zellman (1976), however, noted that students of each of the four cultures argue that the family network and the cultural values function as facilitative and psychologically integrating factors in the lives of elderly (and nonelderly) members. They also claim a greater tendency for increased interaction between generations and for supportive friendships in contrast to the presumed coolness of interpersonal interaction among Anglos.

Differences in Physical and Financial Access

The extreme incidence of poverty greatly affects the ability for elderly non-whites to finance the cost of many services. In large cities where large numbers of elderly non-whites live in Chinatowns, barrios, and ghettos; service providers are often located in more affluent areas. In some rural areas public transportation is nonexistent. Counselors can assist the non-white elderly in establishing self-help centers in previously unserved areas to bring a wide range of programs to the elderly that are otherwise inaccessible. Counselors can also provide much needed information concerning income-support programs.

Differences in Eligibility for Services

It is often assumed that services such as Social Security and other public assistance programs are automatically available for all minority elderly. On the contrary, for example, many elderly Mexican-Americans are unlikely to seek public income supports because they lack documentation of legal residence. Many elderly Asian-Americans, who were interned during World War II, are unaware of their eligibility for Social Security wage credit for the time spent in the camps. There are many problems surrounding the eligibility of Indians for benefits. Counselors can become a valuable resource to minority elderly through their awareness of public assistance eligibility requirements. They can also help eligible individuals complete the necessary applications and get through the red tape to acquire service eligibility.

Minority Representation

A consistent concern in the literature on the minority elderly is their lack of representation on advisory boards and commissions, in agencies and programs serving the elderly, and in training and educational programs. Counselor education programs can make a significant contribution in this area by increasing the recruitment of minority students. Training programs on gerontology should also be developed to specifically train minorities in delivery of gerontological services.

The recruitment and training of non-white counselors has always been a problem within the profession. In the effort to obtain persons who have the training and skills required for working with elderly non-whites, contact with local, state, or national organizations that represent non-white concerns should be made early. Organizations such as the National Center on Black Aged produce newsletters distributed to their memberships that usually include a section on placement information. On state and local levels, minority colleges and universities are valuable assets in recruitment efforts, particularly those institutions that have received training funds from the Administration on Aging.

In communities where minority institutions and agencies are not present, counselor education departments of local universities or colleges or local social service agencies may be able to help in recruiting appropriate people. In short, though it is often difficult to identify qualified minority counselors, the rapidly growing number of the minority elderly in this country warrants the acceleration of such recruitment efforts.

OTHER IMPLICATIONS AND STRATEGIES

What is most alarming to counselor educators and researchers is the scarcity of information about counseling elderly non-whites. The lack of such data greatly impedes both the understanding and development of theories for counseling the minority elderly. The opportunity for counselors to take the lead in mental health research in this area is great.

According to Vontress (1976, p. 132), as a counselor, "It is doubly challenging to work with a clientele that is doubly different." He reports on the problems these differences present and offers ideas for intervention. The problem of communication is magnified unless one is to some extent bicultural and bilingual. If the counselor should require an interpreter, it is probably better to use another counselor or a paraprofessional who is fluent in the particular language instead of asking the client's child, neighbor, or friend to interpret. Important considerations in cross-cultural counseling include an awareness of the importance of respect, privacy, dignity, and shame and the specific implications they have on counseling non-whites.

For example, in Mexican-American culture, a counselor who asks a child to interpret for his or her mother may be seen by the mother as reversing the parent-child roles, which are clearly defined and respected in Mexican-American culture. Another example can be found in Japanese-American culture. Japanese immigrants are noted for their dependence on a very elaborate but subtle system of nonverbal communication. American Indians also communicate with great economy of language. The counselor needs to be aware of the effect of nonverbal communication and to provide ample time for interaction with clients. The so-called nonstandard dialect of Blacks may also be used to hide feelings and true emotions. Just sitting and sharing silence with elderly minority clients may foster the establishment of a trusting and productive relationship. Failure to do so and an evident eagerness to hasten the counseling process often communicate lack of respect for the client.

Vontress (1976) also noted that transference and countertransference often present barriers to effective counseling relationships. For instance, client feelings toward counselors of a different race who are youthful and educated may include a number of inappropriate perceptions such as perceiving the counselor as a grandchild; the client may respond as if s/he were in a grandparent-grandchild relationship as opposed to a client-counselor relationship. According to Vontress (1976), countertransference may occur when the elderly client reminds the counselor of the counselor's own aging, which may cause the counselor to hastily assist or prematurely terminate the client. An early termination of counseling may severely hinder the determination of the client's needs and his/her receipt of badly needed services.

Evidence of dissonance in interactions between non-white clients and white counselors has been documented (Bryson & Bardo 1975). Mistrust, suspicion, anger, pessimism, and negativism characterize and affect many helping relationships including counseling and psychotherapy. Yet, the intent of the therapeutic relationship is to establish mature trust and understanding. Communication is an emotional bridge between the counselor and the client. It can be a first step in establishing rapport. Factors that partly influence the counselor-client relationship are counselor awareness of the client's life style, values, attitudes and communication patterns. Counselor familiarity with these factors can often ease a potentially hostile atmosphere in order for effective counseling to take place.

Smith (1977) suggests that counselors need to adopt more nontraditional roles when counseling minorities. Moreover, counselors' efforts to project middle-class values on clients is one of the greatest hindrances in interracial counseling because it denies the client's value system. Gunnings (1971) postulates that the counseling process itself may be the primary reason that counseling is often basically ineffective with non-white clients. He suggests more action-oriented and externally focused approaches to resolving the difficulties of culturally different clients in addition to new conceptualizations of the role and functions of their counselors. For example, the Black elderly list income as their most pressing problem. A counselor who can help a needy elderly Black client identify sources for and acquire additional income may be held in greater esteem than one who cannot assist in resolving this need.

Gunnings and Simpkins (1972) further elaborate on this "systemic approach" for changing counselors' roles. In this approach, stress is on the counselor's becoming an advocate for his/her clients, serving as an official representative of the client's best interests. For example, the counselor represents an elderly client who has been experiencing difficulty in receiving food stamps to which s/he is entitled. The counselor helps the client by contacting the appropriate agency officials to assure the receipt of the entitled services. The counselor's role is to articulate the feelings and concerns of the elderly client and to function as a friend, helper, and an insurer of fair treatment.

Christensen (1977) notes the importance of the family when counseling Puerto Rican clients: the family serves a very significant function in Spanish and Latin American cultures. He asserts that the closeness of the Puerto Rican family is such that a client rarely discloses family concerns in a conversation with a counselor. There are ways for the counselor to become more involved with the family system of the client, for instance, discussing other family members during the session.

Inquiries that focus on the welfare, education, and activities of the family show concern and interest to the elderly client. Another method the counselor may use is to incorporate the consultant role. In this case, the counselor can work with another family member if the client does not object. There are several points worth mentioning in Christensen's model of the counselor-consultant role:

1. The counselor should be careful not to usurp or try to change established family roles. S/he should proceed with caution while working with the family, remembering s/he is an outsider.

2. The counselor should attempt to help the family consultant (the family member the counselor is consulting with about the elderly client) gain an improved understanding of the elderly client and thereby be able to assist in the client's self-understanding. The focus should not be on peripheral or irrelevant behavior but rather on the behaviors that are significant to the goals of the client. A take-it-slow approach with the family consultant and the elderly client is urged. The rationale for treatment should be explained to the member of the family serving as the consultant.

3. Communication with the family should be based on a thorough understanding of their language, history, and culture.

The counselor can also work with the Puerto Rican family system by being involved and active in the community. This involvement provides unique opportunities for the counselor to become familiar with the family and friends of clients. It also assists the counselor in becoming more approachable.

There can be a conflict between the values of non-Asian therapists and the values of Asian clients. The Western values of being verbal, direct, assertive, and individualistic conflict with traditional Asian values. Asians often perceive a person who is too verbal, direct, assertive, and individualistic as crude and poorly socialized. Moreover, counseling techniques emphasizing these qualities may have adverse effects on counseling elderly Asian-Americans (Tinloy 1978). All the counselors and therapists in Tinloy's study found that they had to integrate or supplement their training with their cultural awareness and experiences in treating Asian clients. The counselors were seen as effective when they were active and provided outreach (home calls). Most counselors found it difficult to get families together for therapy. Counselors who were members of Asian groups themselves reported that many of their clients were experiencing parent-child conflicts directly related to the differences in values between Asian and American cultures. There were also reports of clients experiencing multiple problems.

Well-planned preventive mental health programs are needed. Bilingual and bicultural counselors are desirable. Non-Asian therapists should refer clients to Asian therapists when they cannot communicate effectively with the Asian client. If an Asian counselor is unavailable, non-Asian counselors should consult with individuals who are knowledgeable about Asian culture.

A comprehensive knowledge of the Bureau of Indian Affairs and its social service programs would be helpful for counselors working with the elderly Indian. Welfare counseling is an essential and much needed service in many Indian communities. Despite the fact that many older Indians are poor, many do not receive benefits to which they are entitled. Elderly Indians often find it impossible to acquire welfare benefits when proof of age is necessary for eligibility. Many do not possess birth certificates or other legally accepted proofs. Information concerning social service programs frequently never reaches them because social and language barriers are not considered when agencies disseminate information.

The church has been a source of great psychological strength for many minority elderly. Counselors may use the church for program development as well as for a referral mechanism. Solomon (1977) postulates that large numbers of minority elderly are churchgoers and counseling programs channeled through the churches may prove beneficial. Testimony presented by Davis (1977) in hearings before the House Select Committee on Aging indicated that,

> although lacking in economic resources, Black communities have developed extended family support systems. Often the church, particularly the prayers offered by the pastor and church community, provides the aged sick great psychological healing and comfort. Therefore, I recommend that any guidance program for the aged, sick and disabled, include an expanded pastoral counselor training and services program (p. 63).

Church programs have helped many minority elderly. A specific example is the Spanish Catholic Center in the Adams-Morgan district of Washington, D.C., which has provided an array of services for the Hispanic community there. The director, Father O'Malley, or Padre Sean as the community knows him, has been an energetic adviser to Hispanic-Americans of all backgrounds. Some may have visas, some may not. Most speak poor English, if at all. Many turn to the center as a source of guidance ("Father O'Malley..." 1978).

MASLOW'S HIERARCHY

Some discussion in this module on the relationship of Maslow's (1968) hierarchy of needs to counseling elderly non-whites is necessary. His general motivational hierarchy, from lower-level to higher-level needs includes: physiological needs, safety needs, social needs (those for social approval, affiliation, and interacting with other people), esteem needs (those of self-respect, self-confidence, recognition, and respect), and self-actualization needs. Maslow stresses that lower-level needs must be met before higher-level needs can be obtained. Before a person can develop to his fullest potential and be as complete a person as s/he can (self-actualization) lower-level needs such as the physiological or safety needs must be met in ascending order. For example, a person who is starving for lack of food, a physiological need, is not concerned with social status or approval, a social need, but is primarily occupied with obtaining food. Counselors may find that they will have little effect on helping a client achieve self-actualization if the individual is hungry.

It should be remembered, however, that movement through the various levels is not linear and permanent but fluid. It involves progression and regression as the needs are met or unmet. For example, it is possible that for most of an individual's working life s/he had sufficient income to satisfy such basic needs as food, shelter, and clothing. Consequently, s/he spent relatively little energy addressing these needs and sought to satisfy those of a higher level. If retirement brings a severe reduction in income, then the same individual might revert to a lower need level and be concerned with identifying new ways to satisfy more basic and previously fulfilled needs.

In the literature on non-white elderly groups, their lack of sufficient income, employment, and housing is widely mentioned. For most elderly non-whites nearly all of their income is absorbed in caring for the physiological needs of food, water, comfort; frequently even these basic needs are not adequately met. As for safety needs it is commonplace for elderly non-whites to be more victimized by crime than white elderly Americans. Concerning social needs, elderly non-whites know all too well the social rejection they have experienced as racial minorities in a society plagued with racial injustice. Social rejection coupled with the lack of tolerance younger members of their own group exhibit toward them makes it understandable how many elderly non-whites experience feelings of worthlessness. Closely related is the lack of fulfillment of esteem or status needs. Instead of self-actualization, what elderly non-whites experience, more often than not, are feelings of isolation and loneliness.

The counselor's task of helping elderly non-whites achieve these needs is an imperative. The counselor cannot do it alone. S/he must often rely on social service agencies, other professionals, or paraprofessionals to supplement counseling designed to encourage the self-sufficiency of elderly non-whites. Finally, the counselor can play a meaningful role by helping elderly non-whites to identify and explore the individual skills and abilities they posses. The counselor becomes an essential resource who can serve as a springboard for helping elderly non-whites fulfill their various needs.

CONCLUSION

Vontress (1976) notes that disengagement from central life roles in modern society starts around age 65. For poor minorities it begins much earlier, perhaps around 35 or 40. This is an area that warrants further research. Literature on the disengagement of the various non-white elderly groups is almost nonexistent.

Three basic concepts were frequently mentioned in the research on counseling elderly minorities. Successful use of these concepts may be effective in counseling the minority elderly. The first, awareness, implies that the counselor be fully aware of his or her own attitudes and prejudices so that they will not impede the counseling process. The counselor must also be somewhat aware of the background, values, life styles and concerns of the elderly minority group member s/he will be counseling. Second, the counselor should be able to communicate effectively with the minority elderly client. This may necessitate being bilingual or aware of language resources and also knowledgeable about the various cultural communication patterns. Third, the employment of the advocacy and outreach role as a change agent will enhance counseling services delivery for the minority elderly.

Essential to the needs of elderly non-whites is sensitivity and genuine commitment from the counseling profession. This training module is but a beginning in an effort to address the concerns of a needy clientele. The charge of this module is for each counselor to appoint him/herself as a committee of one to insure meaningful and healthy later years for all Americans.

Individual/Class Activities

ACTIVITY 1 ETHNIC STEREOTYPES

Purpose: To increase awareness of the stereotypes applied to elderly non-white groups.

Directions:

1. Before introducing the topic of elderly non-whites to the class, ask students to write a short one-page essay about their own perceptions of a specific elderly non-white group. (You may ask them to include a discussion of such variables as life style, leisure activities, economic status, mortality rate, etc.). This can be done with individuals or in small groups. Have students present each profile to the class and determine the stereotypes and erroneous information in each, if any.
2. Review the literature to determine what stereotypes are usually applied to elderly non-whites.
3. Survey elderly non-whites to determine what stereotypes are usually applied to them.
4. Survey the general population (do not include elderly non-whites) to determine how they perceive elderly non-whites and what stereotypes are present in these perceptions.
5. After reviewing the literature and surveying elderly non-whites, develop a list of stereotypes commonly applied to members of non-white elderly groups.
6. Share and discuss findings in class.

ACTIVITY 2 ETHNIC COLLAGE

Purpose: To develop participant creativity and sensitivity to elderly non-white life styles.

Directions:

1. Have students select a theme consistent with the life style or life situation of an elderly non-white.
2. Survey magazines, newspapers, and other materials to identify pictures portraying elderly non-whites.
3. Have students cut out pictures of elderly non-whites that best reflect their selected theme.
4. Have students paste pictures on cardboard or some other appropriate backing in a manner that best reflects their theme.
5. Discuss the collage in class upon its completion.
6. Students may choose to do this activity drawing symbolically without using pictures of non-white elderly but other pictures that represent the message.

ACTIVITY 3 PROGRAM DEVELOPMENT

Purpose: To facilitate small group (five members) participation in the development of a model counseling program for elderly non-whites.

Directions:

1. Assume that you have received a $500,000 grant to establish a counseling program for elderly non-whites.
2. Group members should brainstorm purposes, objectives, and strategies for the development and administration of the model program.
3. The model plan should then be formally developed by the group and presented to the entire class for review.

ACTIVITY 4 THE PROPOSAL

Purpose: To increase the advocacy skills and proposal writing techniques of participants.

Directions:

1. Select a small group (three members) to prepare a proposal abstract for funding some program or research activity pertaining to counseling elderly non-white.
2. Assume that the proposal is being submitted to the Administration on Aging, Department of Health, Education and Welfare. (The instructor may wish to use actual guidelines for proposals from AoA to more closely approximate a real experience.)
3. The proposal should answer the following questions:
   a. What is the name of the activity or project?
   b. What is its purpose?
   c. What is to be accomplished?
   d. How will it be implemented?
   e. Who will implement it?
   f. How will it be evaluated?
   g. Is the project generalizable?
   h. Of what benefit will the outcome be to people in other communities, states, etc.?
4. The final draft should be presented to the class for approval or rejection. If it is rejected, the reasons should be indicated.
5. A proposal may actually be submitted to the AoA.

ACTIVITY 5 TESTIMONY

Purpose: To develop skills in giving testimony about elderly non-white issues.

Directions:

1. Select a small group (three members) and prepare and develop testimony for a mock hearing before a legislative committee.
2. Select an important issue concerning elderly non-whites and present arguments pro and con.
3. Enact a simulated hearing using these testimonies.

ACTIVITY 6 THE NEED SURVEY

Purpose: To increase participant awareness of the needs and concerns of elderly non-whites.

Directions:

1. Select a small group (three members) to develop a questionnaire to be distributed to elderly non-whites for the purpose of identifying their counseling needs. The questionnaire should seek information concerning needs and concerns of elderly non-whites.
2. Review methods of test construction and be able to defend the method of development and the format.
3. Collect and analyze the data and share the information in class.
4. Compare responses cross-culturally.

ACTIVITY 7 EXPRESSIONS OF FEELINGS

Purpose: To foster participant sensitivity to the feelings of elderly non-whites.

Directions:

1. Assume that you are a poor elderly non-white. On a sheet of paper, indicate at least three adjectives or descriptions of your feelings and concerns as a poor elderly non-white.

2. Share responses with the class and discuss why they selected the feelings they did.

ACTIVITY 8 ISSUE IDENTIFICATION

Purpose: To broaden participant's perspective of counseling issues concerning elderly non-whites.
Directions:

1. Select an important issue pertaining to counseling elderly non-whites.
2. Prepare a one-page report on the issue.
3. Discuss the issue and report in class.

ACTIVITY 9 CASE STUDIES

Purpose: To increase the participant's awareness of elderly non-whites' lives and concerns.
Directions:

1. Identify and select an elderly non-white for a case study.
2. Conduct a thorough case study on the selected person.
3. Emphasize problems experienced by the elderly non-white and focus on the counseling implications of the study.

ACTIVITY 10 WORKSHOP

Purpose: To facilitate class participation in the development of a workshop on counseling elderly non-whites.
Directions:

1. This activity is a total class project. For the purpose of this activity the class will constitute the workship committee.
2. Select a chairperson (or co-chairpersons) to coordinate this activity and establish several subcommittees with specific tasks.
3. Set time tables, date of the workship, and regular meeting times.
4. Conduct the workshop. (It may serve as a culminating activity for the class.)

ACTIVITY 11 FILM REVIEWS

Purpose: To increase awareness of the media resources concerning elderly non-whites.
Directions:

1. Consult libraries and other media services to determine availability of films.
2. After the identification of films concerning elderly non-whites, the participant should review and critique the films.
3. Emphasize the counseling implications when critiqueing the films.

ACTIVITY 12 COURSE SYLLABUS

Purpose: To stimulate students' consideration of all the issues pertinent to counseling the elderly non-white and to provide the participant with a model course syllabus.
Directions:

1. Select a small group (three members) to develop a model syllabus for teaching a course on counseling elderly non-whites.
2. The syllabus should include course objectives, text, topics and subtopics necessary to present the course, a bibliography, teaching strategies and methodology, and assessment procedures.
3. On completion of the model syllabus, the group will present the completed product to the class for constructive criticism and revisions.

ACTIVITY 13 COUNSELING CENTER EVALUATION

Purpose: To increase the participant's evaluative skills.
Directions:

1. In a small group (three members) develop an instrument for accessing a counseling center's capabilities of providing cross-cultural counseling for the elderly. Assume the center is located in a multiethnic community.
2. Present the completed instrument to the entire class for discussion.

ACTIVITY 14 PANEL DISCUSSION

Purpose: To foster direct contact and encourage dialogue between students and elderly non-whites.

Directions:

1. Select topics for panel discussion. Topics with counseling implications are preferred.
2. Invite elderly non-whites from the community to serve on the panel.
3. Record the panel discussion and distribute to class participants.

ACTIVITY 15 CRITIQUES

Purpose: To increase the participants' awareness of the literature on elderly minorities.

Directions:

1. Review five articles or books on elderly non-whites.
2. Critique readings on separate small index cards.
3. Include the counseling implications of your article in each critique.
4. Participants may discuss their critiques in class or individually with the instructor.

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FILMS ON THE MINORITY AGED

Taken from: *About Aging: A Catalog of Films*. (rev. 1977), Compiled by Mildred V. Allyn. Ethel Percy Andrus Gerontology Center, University of Southern California, Los Angeles.

A WELL SPENT LIFE — 44 min/B & W/1970

Mance Lipscomb is a 75-year-old black songwriter-guitarist — a sharecropper in rural Texas all of his life. Only recently has he been recorded by a record company. The film is replete with his blues music and his comments about his past, his marriage, about religion, blacks and whites, and his love for young people, particularly the 23 children he raised.

LEGEND DAYS ARE OVER — 15 min/color/1974

This film focuses on the thoughts and feelings of an elderly Indian woman of the Nez Perce tribe. The "legend days" are the days of the Indian past; we know why they are over. Against a background of Idaho mountains, valleys, and pasture land, the woman's voice laments the changing times, remembering the way life for her tribe was before the machines took over. She anticipates her own death knowing the legends are past, now the death days are here. Award winning.

MAN NAMED CHARLIE SMITH, A — 26 min/B & W/1965

Through the memories of a man named Charlie Smith, 120 years old, this film shows the history of slavery and the black man in America. In 1854 he was brought to America on a slave ship. He tells of his experiences, adventures, and misfortunes. His humor and his wisdom help to put the country's history into perspective in a unique and moving way. Narrated by James Whitmore.

NEW WINGS FOR ICARUS — 30 min/color/1968

Black 72-year-old John Davis lives all alone. For months he has known that every house on his block will be razed as part of an urban renewal project. He is adamant in his stubborn refusal to vacate his home. The entreaties of his friends and neighbors fall on deaf ears. The "authorities" finally use force to remove the weeping old man from his home. How the neighborhood pastor and the church's social worker brought the power of the Gospel to bear on the life of the elderly Mr. Davis is brought out in the closing action of the story.

OLD, BLACK, AND ALIVE — 26 min/color/16mm film. Distributed by the National Center on the Black Aged, 1830 M Street, N.W., Washington, D.C. 20036. $350 sale.

Filmed in Macon County, Alabama; depicts a variety of life styles among aged Blacks in that area and provides significant insights on social stratification, activity and inactivity, and good and poor health among the aged Blacks. The film also shows some of the needs and problems, and some of the ways in which individuals and public and private agencies assist in helping to resolve these problems.

SAM — 20 min/B & W/1973

This film explores the "private" life of a Japanese-American whose "public" image is that of a Japanese gardner in the Los Angeles area. He is shown talking of his family and past: a number of his clients talk about him. He talks about his World War II experience; his wife — who was living in Hiroshima at the time — speaks about her life and his. The ending shows them having weathered the past bitterness, but with a touch of disappointment.

TAKING CARE OF MOTHER BALDWIN — 20 min/B & W

This film explores the texture of the rural south and the relationship between an elderly black woman and a young boy. It attempts to point up the benefits and opportunities as well as the difficulties of rural living.

WATARIDORE: BIRDS OF PASSAGE — 30 min/color/1975

A biographical account of three Japanese-American older people, given in an effective manner which sensitizes the audience and provides a solid base of knowledge with which to better understand the Issei (first generation Japanese in America). As the continuity of their lives is portrayed, it is evident that the strength and pioneer spirit that enabled them to immigrate to and survive in a foreign land also equips them in their later years. The film also acts as a model for the utilization of older people in teaching history and culture and serves as a dynamic educational tool about successful aging.

WITH JUST A LITTLE TRUST — 15 min/color/1976

An elderly black woman, her feet swollen with arthritis, marches with pride and determination through an urban ghetto. This, and gospel music, set the tone for a film that is a beautiful tribute to the indefatigability of the human spirit. The woman is on the way to help her daughter, a widow with three children, with "after work" chores. In the events which follow, the older woman, by her faith, determination, pride, and refusal to give in to self-pity, bolsters her daughter's sagging courage in the face of almost insurmountable obstacles. Award winning.

ORGANIZATIONS

National Center on Black Aged
1424 K Street, N.W., Suite 500
Washington, D.C. 20005
(202) 637-8400

National Indian Council on Aging
P.O. Box 2088
Albuquerque, New Mexico 87103
(505) 766-2276

National Association for Spanish Speaking Elderly
1801 K Street, N.W., Suite 1021
Washington, D.C. 20006
(202) 466-3595

Asian-American Mental Health Research Center
Ad Hoc Task Force on Aging
1640 W. Roosevelt Road
Chicago, Ill. 60608

Evaluation and Assessment

1. Discuss and present a rationale for why the counseling professional should focus on elderly minority groups.

2. Discuss the four elderly minority groups presented here in terms of their unique needs and concerns and their similarities and dissimilarities. Elaborate on each group.

3. List and elaborate on some considerations counselors should be aware of when counseling elderly minorities. Give examples to support your comments.

4. Give an example of a strategy that may be employed when counseling a minority client. Elaborate.

5. Discuss what avenues you as a recruiter would undertake to insure the identification of prospective non-white applicants for positions of employment and graduate school admissions in counseling the elderly. Be specific.

6. Discuss the importance of understanding the culturally different. How does it affect counseling?

7. Consider the four groups of elderly minorities in this module. What concerns do they have in common?

8. As a counselor, what efforts can you make to assist in resolving the problems of the minority elderly?

9. Consider an elderly Mexican-American who speaks no English seeking assistance from you as a counselor who speaks no Spanish. How would you help your client?

10. Discuss what services, agencies, and programs are responsible for assisting the elderly. How can they become more responsive to the needs of the minority elderly?

11. Discuss factors that affect the delivery of counseling services to the minority elderly. What are their effects?

12. In what ways can you develop good counseling skills in counseling the minority elderly?

13. Evaluate yourself or your counseling service. Is there discrimination? If an elderly minority client who speaks no English came to your center, would you be able to communicate with him/her? If not, precisely how would you handle the communication problem? Are you aware of the eligibility requirements for old age benefits, Medicaid, Medicare, foodstamps? Is there minority representation on your staff? Is your service near or accessible to the minority elderly?

14. Discuss an effective strategy for counseling or providing services to a minority elderly person.

15. What are some dos and don'ts of counseling the minority elderly?

MODULE VII

COUNSELING OLDER ADULTS: SUGGESTED APPROACHES

Alfred R. Wolff

Goldye W. Meyer

Most of Alfred Wolff's professional life has been in the field of college student personnel services at the University of Bridgeport where he served first as Director of Counseling and then for many years as Dean of Student Personnel. During this time he has been president of the Connecticut state branch of APGA and for the past 22 years executive secretary of the New England Personnel and Guidance Conference. He was the recipient of the Distinguished Service Award of CPGA in 1973 and in 1977 the National Association of Student Personnel Administrators presented him a Distinguished Service Award for his work in Region I.

In 1975, after more than 28 years in Student Personnel Services, he left his position to follow a new interest, counseling the aging. As a Professor in the Department of Counselor Education and Human Resources at the University of Bridgeport, he initiated a specialization in this field and has observed a quadrupling of its enrollment in the past three years. He developed a series of teaching techniques involving affective learning and demonstrated many of them at various workshops and conferences including national conventions of the American Society of Group Psychotherapy and Psychodrama and the American Personnel and Guidance Association.

Goldye W. Meyer is Professor of Counselor Education and Human Resources, University of Bridgeport, Connecticut. She has been with the University of Bridgeport for 14 years during which time she had various teaching and administrative appointments. Goldye is an active consultant to many business and educational institutions throughout New England, specializing in Human Relations and Human Resource Development. She is a member of APGA, APA, and other professional organizations and has presented workshops and papers at regional and national conferences.

She has extensive training in various therapeutic approachus including gestalt, transactional analysis, and bioenergetics. Presently she is affiliated with the New York Institute of Bioenergetics and is in the postdoctoral training program.

Goldye is a "re-entry" person, having dropped out of college to marry, have three children, and later return to continue her education and establish her profession. As a result of her personal experiences and research she became actively involved in developing mid-life counseling programs at the university and in the community. Through her interests in mid-life counseling and community mental health she has also become actively engaged in training counselors to work with the aging.

ACKNOWLEDGMENT

Since the initiation of the counseling the aging program at the University of Bridgeport three years ago, I have enjoyed a shared learning experience with my students, many of whom were already deeply involved and knowledgeable in the field of aging, Eight of these students were particularly helpful to us in researching materials related to this module. Goldye Meyer and I give special thanks to Ellen Gordon, Joanna Elias, Aviva Cohen, Barbara Demnerle, Carol Guilbert, David Huff, Carol Cohen, and Barbara Grabowski.

COUNSELING OLDER ADULTS: SUGGESTED APPROACHES

Rationale and Objectives

It is tempting but precarious to assume that skillful counselors can redirect their professional efforts to diverse target populations without specific training. Professional training has focused on developing counselors who can facilitate growth and change in others through the use of human relation and communication skills and of modeling behaviors that bespeak openness, caring, self-awareness, and self-confidence. Rogers (1957) identified empathy, genuineness, unconditional positive regard, and congruence as necessary counselor traits. Other notable writers have alternatively expanded, interpreted, and often translated the Rogerian traits into discrete skill-training models (Combs 1969; Brammer 1973; Carkhuff & Truax 1967; Okum 1976). Generally, they are accepted as basic and essential process goals for effective counselors.

Acquisition of these traits and relationship skills is certainly critical for counselors, but effective application and implementation with special groups requires additional training in two obvious areas. Counselors who plan to work with the aging and the aged need training programs to broaden their knowledge about the group and the issues that confront it and to explore their own values, attitudes, and biases about aging and the aged.

To meet these two needs, a training program should (1) provide a supportive climate in which counselors can re-evaluate their personal biases and determine their learning needs; (2) establish clear objectives; (3) develop appropriate counseling techniques and activities; and (4) evaluate personal and program effectiveness. The processes, procedures, and skills presented here are not necessarily unique, but they show how a program can integrate previous training experiences with new and pertinent models of interventions with aging clients. What is presented here is a mere sampling of the vast resource of materials available for training. Instructors should expand the experiences given here with their own material and procedural adaptations.

The aim of this module is action. Experiences will focus on preparing the counselors themselves and supplying procedures for them to deliver their services to older adults. The contents are designed to achieve the following:

(1) Counselors will explore their feelings about aging of self and others. Counselors need to confront their own aging process, to sort out personal fears, values, and attitudes regarding aging and the aged; they need to recognize how these attitudes affect their clients.

(2) Counselors will examine personal and social values and attitudes about aging and the older adult. Common stereotypes of older adults and myths about the aging process will be explored, i.e., physical and mental capabilities, sexuality, creativity, aspirations, etc. The destructive and limiting effects of the myths and stereotypes will be examined in the context of program development and enabling activities for the aging.

(3) Counselors will develop procedures and processes to help them become more sensitive to and more accurate in understanding the feelings of the older adult. A loss of visual and hearing acuity, withdrawal due to anxiety, and other factors may unwittingly block the counseling experience. Skill areas such as attending, listening, responding, decision-making, etc., will be re-examined and adapted for specific application with the aging.

(4) The counselor will explore techniques for counseling the older adult. Some older adults may shun opportunities for personal and group counseling because of internalized attitudes equating the counseling experience with weakness and/or mental illness. Counselors need to recognize the etiology of resistance in older clients that may prevent them from verbalizing private concerns (see Modules VIII, IX). In order to gain acceptance for personal and group procedures, a variety of nonverbal and other nonthreatening approaches are suggested to supplement verbal counseling procedures.

(5) The counselor will learn to identify critical issues of aging and develop appropriate skills for preventive, developmental, and remedial intervention. The critical issues for the aging develop from personal experiences and social expectations. Counselors can assist the older adult in moving through life stages by providing important interventions, i.e., mid-life career counseling, retirement counseling, counseling for death and dying, death and living, loss of mate and peers.

(6) The counselor will develop skills for promoting community and family understanding of problems of the older adult. Counselors need to become community change agents and advocates for the

aging. False stereotypes and unreal expectations have resulted in community and family misunderstanding and mistreatment of the aging. The counselor can provide powerful linkage between intergenerational cohorts, between the aged and communities, and among the various older adult groups.

(7) Counselors will evaluate their own response to aging clients and the effectiveness of various intervention procedures. Continuous self-evaluation is a critical component of any program. Counseling the aging is a relatively new venture that will demand extensive experimentation and innovation; it requires constant examination to ensure effective results.

Content

GENERAL PRINCIPLES

The aged constitute a group whose particular needs and problems warrant the special attention of counselors preparing to work with them. The objectives of this module point out areas that require specific training of counselors for older adults and express the differences that may exist between counseling older and younger people. While they must recognize and respond to differences, all counselors share the common foundation of human development. The individual's development is continuous over a lifetime; a person grows old gradually and does not become old suddenly or change drastically on any given birthday.

Similarities

Counselors in general need to develop the traits defined by Carl Rogers. Carkhuff (1972) expanded these and classified them as facilitative (empathy, respect, warmth, concreteness) and action (genuineness, self-disclosure, confrontation, immediacy) behaviors. Ivey (1971) suggests that skilled counselors must learn to attend, listen, and express in the counseling interaction. There is agreement in the literature that the counselor is a: a) developmental facilitator who focuses on growth and change; b) resource person for information and skills; c) community change agent and advocate for client populations; and d) program developer. In short, regardless of philosophical orientation, a counselor is expected to have enabling skills that help clients take and maintain control of their lives.

To summarize, the skills most commonly cited as requisite for all counselors are: 1) developing empathy and genuineness; 2) establishing basic trusting relationships; 3) communicating; 4) identifying and understanding feelings and thoughts; 5) exploring feelings in a supportive manner; 6) devising appropriate ways to deal with diverse problems. All counselors also need a basic core of knowledge about human behavior, and all need to develop an awareness and keen understanding of self.

Potential Differences

There is considerable variation in the aging process and individual differences must be understood and respected. Those referred to as "the aged" are a heterogeneous population in chronological age, financial circumstances, health, degree of independence, attitudes, etc. Given these variations, there are some differences between counseling the young and the old.

To varying degrees aging may bring on significant physical changes such as hearing, sight, and sometimes memory losses. Counselors may need to sit close, face the client directly, and speak especially clearly. The counselor should observe how well the older person can process and digest information and, if necessary at times, should comment or respond more slowly, distinctly, and briefly. If the client is taking medication, it would be helpful for the counselor to know its effects (see Module III for additional information).

Older people generally become involved in a microenvironment. They have fewer "human relationships" as family members and old friends die and new friendships become more difficult to make as physical and financial limitations increase. The counselor will have the opportunity to fulfill clients' needs and expectations that in earlier training s/he may have been told to avoid. The older person is less likely to seek counseling assistance than the young adult but may be eager for a listening ear. The older person may need an advocate, a friendly listener, a companion, and someone who can give and receive affection. The counselor needs to point out attractive alternatives for consideration as the client's options diminish with advanced years. The counselor must be prepared to act as a change agent in the community of the older client and to use effectively the community resources available to the older population.

The value system of older persons may be different from that of the young adult. Long hair, patched dungarees, and racy language that might endear a counselor to high school and postsecondary school students might, at least initially, be offensive to the older person. Of course, value systems vary within the older population just as they do within younger age groups.

Older persons not only need to fight the negative attitudes of much of society toward the aged, but possibly their own internalized negative attitudes toward aging. These may affect their feelings of self-worth and their life styles and goals. The counselor may, therefore, find it important to help some older clients distinguish between the myths and the realities of aging and become sensitive to their individual needs and aging processes.

Older adults may tend to focus on relatively immediate plans while young adults can realistically contemplate a more distant future. The counselor thus may need to deal more frequently with the present when working with older persons. On the other hand, the counselor can use the older person's plethora of past experiences productively, applying the technique of reminiscence.

As do people of all age groups, older adults often experience developmental crises or transitions (see Module II). Unlike other age groups, however, the aged face developmental transitions that frequently require adjustment to loss(es). These crises are not experienced by all older persons nor are they exclusive to the aged population, but they must be faced by many older persons and counselors must be prepared to render special assistance during these transitions.

Further Practical Considerations in Counseling Older Adults

To establish a relationship conducive to effective counseling, the professional should convey respect for the dignity and worth of the older individual. S/he has gone through many experiences, been a part of history, probably contributed meaningfully to the lives of other people and to a career. Because some older persons may be reserved and less confident, more time may be needed to establish rapport with them. Attempts at quick intimacy may prove counterproductive. Addressing the older counselee by first name for example, may be interpreted as indicating a lack of respect. Warmth is better communicated by attention to politeness.

Some older persons, more so than their younger counterparts, look on counseling as a sign of weakness. They may believe that their willingness to take part in the counseling process reveals to others a mental illness or a need to be told how to live their own lives. The counselor, therefore, needs to structure the counseling process carefully to emphasize the opportunity for clients to consider various options, to know themselves better, and to take responsibility for their own decisions. The counselor should avoid giving dogmatic answers and fostering dependency; s/he should help clarify choices rather than offer handy prescriptions.

Nevertheless, the counselor must be ready to get involved in ways not ordinarily expected in counseling other age groups. Poor health, limited transportation facilities, and other factors related to aging may require meeting in a location other than the counselor's office — perhaps in the client's home. Attention is often geared to practical matters like managing finances, obtaining food stamps, and collecting Social Security checks rather than traditional psychotherapeutic counseling. The counselor needs at least a general knowledge of the legal and financial matters affecting the older population and community resources for further information and help. The older person's counselor need not be limited to problems of personal adjustment.

Many older persons are particularly concerned with protecting their right of privacy. Many are not used to openly discussing sexual behavior, financial problems, and personal inadequacies and may consider such talk inappropriate and embarrassing. The counselor must establish a permissive atmosphere, encouraging the client to talk freely by making it clear that what takes place will not be revealed to anyone without the express permission of the client.

The use of the counseling interview. Working with older adults may require special sensitivity to the attention span and physical discomfort of the client. Does the client show fatigue or give signs of restlessness? The time allocated for a counseling interview should be flexible. The traditional fifty-minute session may be much too long. A straight, hard chair for the person with a back ailment should be included as part of the office furniture. A break for coffee or tea may increase rapport and provide the client a chance to flex stiffened body muscles and joints by shifting positions, standing up, or walking around the room. As in all interviews, counselor responses should be worded clearly and concisely. It might be helpful to avoid current slang. A request for feedback may often be necessary. Does the counselee hear what was asked, does s/he comprehend the counselor's statements? Some older persons may feign understanding rather than admit difficulty hearing or lack of understanding.

Testing the older client. Testing is frequently a source of anxiety for clients of all ages, but in the authors' experience, anxiety is particularly manifest with older persons. Older persons may think their ability to comprehend new materials has drastically diminished. This usually inaccurate idea is reinforced by the popular arguments for mandatory retirement. Older persons who completed formal education many years earlier may feel unable to compete with members of younger groups. New students in counselor education programs who are in the middle or later years often express fear of competing with younger students they consider more alert and intelligent. Older students generally prove themselves at least as effective as their classmates, but their anxiety must be recognized and dealt with.

Is it necessary to test older persons? Can past experience, behavior, and achievement give enough data to identify counseling needs? If testing is desirable, deal with the counselee's feelings about it. Be sensitive to whatever might cause test anxiety. For example, explain that a test is only one measure to help the client determine his/her own life/career choice (if that is the focus of the counseling sessions). Explain the limitations of test scores and compare them to other ways of obtaining information about oneself. It may be appropriate to limit the use of tests for the older counselee to interest and value judgment inventories. Make certain the client understands the difference between these and measures of general or special abilities.

Sound test administration will help take the mystique out of testing. Some older persons who can't hear oral directions clearly may need the counselor to speak slowly and clearly and grant time for questions before the test begins. Testing for more than an hour at one session may cause fatigue and penalize the older person. To enhance the testing situation, assume a friendly, supportive attitude and use a familiar, comfortable room. If individual testing is impractical, limit the number of persons who will be examined at the same time.

Focus of group counseling. Because it usually takes time for a group of older people to get used to discussing personal concerns openly, basic survival needs often must be handled initially. Often a group counselor with a preconceived idea will be frustrated when members select topics that seem, at least on the surface, better handled by someone with less professional training. But practical topics are not only important to the group's welfare, they afford an opportunity to build support and mutual trust among the members and with the leader. Meaningful discussions on self-awareness, self-development, and interpersonal relations may follow.

Before the group is ready to go beyond the common problems of everyday living, the counselor should consider the backgrounds and beliefs of the participants. Some value systems and taboos have deep roots originally developed in less permissive days. An interchange of concerns and ideas on emotionally charged or highly controversial subjects may be beneficial, but individuals must be informed of their right to refrain from participation, even by physically withdrawing from the room if they choose.

Established routine and follow-up. Schedule meetings at regular times and usually at the same place. Routine can bring comfort, while unexpected changes may produce anxiety in older clients.

Older people with health and transportation problems may miss meetings. Contacting younger adults about their absences from group meetings may be a questionable practice, but it is generally in order for older group members. Express an interest in his/her attendance and welfare and offer help with transportation or whatever the person needs to continue his/her involvement with the group. Show support for and interest in each member not only at meetings but during the time between them.

PREPARING THE COUNSELOR

Counselors must begin with the adage, "Know thyself." How we look at our own aging, particularly our anxieties and fears and even our denial of the aging process, can be a key factor in the success or failure of our role as counselor and helping agent to the aged. Identifying our feelings about significant older people throughout our lives and our present feelings toward people in their later years is also important. Are we impatient? Are we empathic? Are we emotionally involved in ways that may be counterproductive, such as encouraging dependency and child-like behavior rather than independence and self-fulfillment as much as possible? Can we distinguish between myths and realities of aging? What stereotypes do we hold and what values affect our counseling with this population? How a counselor answers questions like these has a profound effect on his/her ability to counsel effectively with older adults.

Following are experiences an educator might employ to help students identify their feelings about aging. In all activities where a large group experience is followed by small group discussions, the smaller groups should be organized before the large group experience begins. That way students can move quickly into small groups and begin processing the experience. In all guided fantasies described in this module, the instructor must first relax the students and then use his/her own words to develop the experience. Speak slowly and distinctly and pause at appropriate times to allow the participants time to imagine what is happening and to contemplate responses as called for.

Experience 1. Meeting Ourselves When Old: A Guided Fantasy Trip

Goal: The participants will examine their own feelings about growing old.

Time: 30 minutes

Procedure: The students are seated in a large circle for the experience and divide quickly into groups of six persons for processing the experience immediately after it takes place.

Describe as vividly as possible a rural setting with tall trees, a dirt road, etc., but do not give details as to the appearance of a farmhouse where the participant meets his/her "old self." This can color in either a positive or negative manner the participant's picture of what is ahead for him/her in "old age." (The following description can be altered to an urban setting if rural living has not been part of the students' experience.)

Relax... Your eyelids are heavy. Close your eyes. Picture yourself walking along a country road, a black top, ruts, dusty, tall trees on each side. On your left is a meadow with haystacks. It looks inviting. You leave the road and wander through the meadow. You see daisies and buttercups and high grass. Your spirits soar and you lope along for some time. At the end of the meadow is a narrow dirt road. It is unfamiliar. You walk a long time. (Indicate this by tiredness in your voice as you go on and on and on.) At last! You can see a farmhouse some distance away. You are lost. You wish to ask directions. You decide to go into the farmhouse. You knock on the door — a long wait. An old person answers. You look closely, very closely. The person looks somewhat familiar. It is yourself when old. Look at yourself carefully. What do you look like? ... Introduce yourself — your self today to your older self. You are invited in the house. What room are you in? What does it look like? How do you feel? Strike up a conversation. Ask yourself what it is like to be old? ... Ask what has happened to you since you were my age? ... What advice would you give me on how to live my life from this time until I reach your age? ...

It is time to say goodbye. You are returning now to this room — to today.

Have students form into small groups as previously arranged and process this experience for 10 minutes. There are no further instructions given to the small groups. When the participants are reassembled in a large circle, ask them to compare their experiences.

Responding to the students' feelings, the instructor should emphasize matters that seem significant: "For some of you this appeared to be a pleasant experience and you seemed surprised by it. You liked your old self. Others seemed depressed and sad. What does this mean to you?" "Others looked at your old self and saw your grandmother or your grandfather. What does that mean to you?" "Might any of your reactions influence your effectiveness as a counselor? In what ways?"

Experience 2. Our Life Story: Past, Present and Future.

Goal: Students have an opportunity to review their past and contemplate the future.

Time: 60 minutes

Procedure: Ask students to draw a line or in some way graphically show their life story from birth to the present in terms of significant changes in their lives. Peak periods, ups and downs, should be shown. Then ask them to think of their future and after a few minutes continue drawing their life line from now until death. This experience is again shared with their partner or small group and the same processing takes place with the entire class.

Some relevant questions or comments might include: "What did you feel?" "How did you feel about your aging?" "Will the way you lived your past affect the way you will live in the future?" "Do you make changes or do you wait for events?" "Can you use this teaching device with groups of elderly persons?"

Experience 3. What's Important to Us? A Look at Our Roles and Needs Now and in the Future.

Time: 40 minutes

Procedure: The students form groups of 5-7 persons. Ask them to search their pocketbooks or wallets for three items that are important to them. Then ask them to consider what roles the items represent in their lives. Remind them to focus on roles the items suggest: a dollar bill might represent the role of consumer; the picture of an eight-year-old, a mother of young children; an I.D. card, a graduate student. Have the students explain the meaning and importance of each item to them and its connection to one of their life roles. With the students still in small groups, invite comments on their reactions to the exercise.

Ask the participants to take a piece of paper and fold it in half. They should then list five of their present roles on the upper half of the page. When all are finished, have them list on the lower half of the page from five to ten needs that their roles satisfy, such as food and shelter, status, affection and love, and self-fulfilling activities.

In the next step tell the class, "You are now 75 years of age and have been retired for 10 years. Cross out the roles you no longer have." After giving the students time to do this, ask, "Will you be a son?" "Will you be a worker?" "How are those needs you listed on the lower half of the page affected?" "If you have a career and you face retirement at a fixed age, will you experience a loss of roles? What will this do to the fulfillment of your present needs?" "What is 'retirement shock'?" "Do you have a better understanding of it now?" "Do you know of anyone who has experienced 'retirement shock'? Tell us about it."

Some of the possible causes of 'Retirement Shock' are loss of prestige and power, loss of established routine, loss of social contacts—particularly with associates during business hours—loss of personal esteem, or loss of life purpose.

This activity emphasizes role changes and the importance of preretirement and life goal planning for the later years. Life can have zest and bounce in the future. New roles can be found or some of the old roles can be developed to meet needs that otherwise might get neglected as roles are lost.

Experience 4. Graveyard.

Goal: Students will concentrate on the meaning of their life by facing their death.

Time: Part 1, 35 minutes. Part 2, 20 minutes.

Procedure: For Part 1, students are divided into small groups. Each group should have a skilled facilitator who has a workable knowledge of the grieving process. Sometimes students who already have shown competencies in group work skills, after some preliminary briefing, can adequately handle this assignment. Give the following instructions:

You are walking along an open road and on your right you see a graveyard. You are drawn toward it and notice that there is a new tombstone with some freshly dug dirt nearby. You pause to read the tombstone. You look closely. You are startled. You see your name.

Draw a picture of this marker or tombstone with the day you were born, the day you died, and what you would like inscribed on it.

When the students are finished, have them share their drawings with other members of their group. They should discuss their reactions to the total experience, their own death, how they wish to be remembered, and what's most important to them in life.

The exercise can end at this point or be continued with Part 2 as follows:

Look. People are arriving. They are coming to your burial. Who are they? How are they acting? What are they saying? How do you feel about this?

Experience 5. Looking Back.

Goal: To provide a pleasurable experience that will strengthen interpersonal relationships among members of the group.

Time: 50 minutes

Procedure: Ask students to select partners before starting the exercise; then take them on the following guided fantasy trip:

Think back on your life. Return to your childhood. Where did you live? Approach this town or village or city on foot. What do you see? Observe carefully. Does it evoke any special memories? Can you get in touch with any of the old feelings you had. Walk around the neighborhood. Glance around. You see some people you knew at that time. What do they look like? What are they saying? Join them. Re-experience some of the activities you shared with them many years in the past. Picture what was happening in detail. What were you doing and saying? Allow your mind to wander freely back to these days, back to people you knew, back to what you were doing and saying and thinking...

Go off with your partner. One of you will spend the next fifteen minutes in recounting significant aspects of your life—the ups and the downs. The listener will be attentive and only say enough to facilitate sharing of memories.

The fifteen minutes' time allowance has expired. Reverse roles for the next fifteen minutes.

After the experience, ask the students what it meant to them. (While reminiscing is presented here as a sensitizing activity for students, it has been found to be a useful counseling technique for both individual and group counseling with older persons.)

The preceding activities or variations of them can help students identify any of their attitudes and biases that could interfere with or enhance their work with older adults.

The Basics

Maslow's Hierarchy of Needs (Maslow 1968) demonstrates the importance of the basics. Counselees who lack enough food to maintain health or who lack adequate shelter must fill these basic needs first. Therefore, gerontological counselors ought to know which community resources aid the impoverished and have the funds or services to supply essential needs. Once these are met, counselors also need a working knowledge of other resources important to the general welfare of the elderly. The long list of organizations offering services to the elderly would certainly include the local Department of Social Security, nearby colleges or universities, the Department of Social Services, the Visiting Nurses Association, a family counseling service, emergency care resources, homemakers, nutrition centers for the aged, hospitals and nursing homes, the regional department of aging, Comprehensive Senior Citizens Centers, etc. Of course a list is not enough. Counselors must know how to obtain these services for emergencies and for long-term help for their clients. What services are available in the community? What do you know about them? What are the names of some people who can be contacted? How is a referral made? Have you involved the counselee to the fullest extent in the referral process or in the request for help? Consider these questions with the members of the training group; they will usually have considerable expertise. Use the following exercise to inform students which agencies and organizations serve the aged in their community and how to use them. This exercise can be enriched by class or individual field work and by conferences with key staff members.

Experience 6. Meet the Bureaucracy.

Time: 60 minutes

Goal: To help students become oriented to local community resources.

Procedure: Working with a group of students in advance of the training session, make a list of situations where a client might need the assistance of different agencies. For example: "My father died recently and my mother is very lonely and depressed." "I am retiring in five years. Is it wise to prepare for this? Whom would I see?" "I want to eat my lunches at the Nutrition Center but there is no way for me to get there." "My Social Security checks are less than they used to be. That doesn't seem right." "My mother doesn't need a nursing home but she does need home care." Add at least twenty other situations to the list. Then assign members of the group to role play representatives of at least ten agencies or organizations. Set up a desk with a sign for each agency and a table with a sign, "Self Help." At the regular class session divide the other students into groups of three and give them the list of problems. Have each group choose a problem and go to the desk of the agency representative who would be most helpful with it. If the group goes to the proper agency, the representative initials the question and the group works on another question in the same manner. If the group chooses the wrong agency, the "representative" of that agency refuses to initial and offers no further help. The group must then seek another agency. Each group has the option to go to the "Self Help" desk and present a proposal solving the problem without the services of any particular organization. The "Self Help" representative will initial approval only if the proposal, as first suggested, appears feasible. The group that solves the most problems within twenty-five minutes wins.

COUNSELING INTERVENTION PROCEDURES

Older adults have been identified as a group with special needs, problems, experiences, and expectations. These critical age-related issues suggest directions for counseling interventions. Counselors need to understand how counseling procedures and interventions are adapted and tailored for effective use with older people. The processes they use must be shaped by the content — clients and their specific issues. This section will focus on the integration of process and content in counseling with older people.

Before studying this module, counselor educators and counseling students should already have acquired basic skills for use in both individual and group counseling. They will also need to understand the cognitive information about older adulthood provided in the other modules (except Module X). This module will demonstrate the transferability of counseling skills when complemented by an adequate understanding of the population to be served, in this case, older adults. The theories and techniques of counseling incorporated in this module are used merely for demonstration, not endorsement. Many theories and techniques of counseling have similar adaptability to older populations.

Listening Skills

Too many people believe that the "elderly" automatically become child-like and dependent. They speak at the older person rather than listen. They use power and authority instead of understanding and respect for the dignity of the individual in his/her later years. Thomas Gordon's books on effectiveness training (Gordon 1970, 1974) for parents, teachers, and youth have significantly contributed to the use of active listening between and within these groups. The concepts of active listening can also be used with older people, as the following exercise demonstrates. (Much of what follows is based on Gordon's work and incorporates some restricted instructional materials for Licensed Effectiveness Training Instructors. The materials are included with the publisher's permission. It is assumed that counselor educators are already familiar with the concept of active listening.)

Experience 7. Am I Not Human Too? Listening with Sensitivity.

Time: 90 minutes

Procedure: Ask students to write brief responses to a series of statements. Advise the students to observe your tone of voice, facial expressions, and body movements while they listen to what is being said. Before each statement, state the role to be enacted (such as an elderly woman in a nursing home or a recent retiree). Pause for a few moments after each statement to give students the opportunity to write how they would respond.

1. I was looking forward to retiring. But it is so dull. You can get really tired of reading the paper, mowing the lawn, driving to the store and then just plain sitting around.
2. The food at this nursing home! Same old stuff. Meatloaf Thursday, fish Friday, hot dogs Saturday, and all so tasteless.
3. I'd drop around and they'd say, "Hi, Joe, how are things?" But they don't really listen. I'm not really with them anymore.
4. What would you do if you kept going around from one employment agency to another and everytime you told them you were 66 they'd say, "But we just don't happen to have anything right now." (sigh) I might as well stay home.
5. This neighbor of mine. She's always pushing her nose into my business. She barges into my room without knocking throughout the day and asks me all sorts of personal questions.
6. Have you ever sat for hours with some one without saying a word? That's how my wife and I spend our time half the week.
7. I feel I'm not wanted. My children and grandchildren try hard to work things out. But I know my living puts a crimp in their lives.
8. Down here at this club they treat you like a child or a doddering old idiot. They tell you its milk and cookies time or you can't play cards because they are having a discussion on cooking. They can have their Senior Citizens Center and I'll give them an idea of what to do with it.
9. Sure I have aches and pains. But these are good years. I enjoy the interesting programs on TV. I see the boys and my grandchildren at least twice a month and your visits always brighten up my day.
10. Listen, you. You may work for the city and have a college degree but that doesn't mean you have all the answers. I didn't ask to see you!

When the students are finished, distribute copies of the above statements with a copy of the "Dirty Dozen Roadblocks," listed on pg. 183, from Gordon's book, Parent Effectiveness Training (p. 41-44, 1970). (The word "person" has been substituted for Gordon's use of the word "child.")

When the students complete the task, ask them to review their responses and note what road blocks they used. Encourage them to share them with the class. The instructor can serve as a model of active listening skills in responding to the students.

Many students become angered at what might be termed roadblocks, claiming (often with justification) that they have successfully used similar responses as helping agents. While there are different schools of thought and different approaches to effective communication in counseling, this session focuses on Gordon's techniques of active listening, essentially a Rogerian, client-centered approach.

Finally, respond to each of the statements previously given with the roadblocks described by Gordon, and ask the students to comment on their reactions to each response. Soliciting statements as to why "roadblocks" can be detrimental to effective communication can be helpful. Some of the key points made by Gordon in restricted instructional materials available only to Licensed Effectiveness Training instructors (p. B-7), read as follows:

1. All carry some risk of blocking communication or hurting the relationship.
2. Most . . . imply a desire to change, control or modify the other. They communicate, "I do not accept you as you are."
3. Some take responsibility away from the other — responsibility for thinking through the problem, for finding a solution.
4. Some have a high probability of making the other defensive, resistive, resentful.
5. All carry "hidden messages" such as "I don't trust you," "Your judgment is poor," "You're bad, wrong."
6. Some carry the risk of making others stop talking.

Next ask the students to name the feeling conveyed in each of their responses to the ten statements listed on this page. It may be helpful to give them a list of feelings to work from. Many of them may already know how to respond to express their understanding of another's feelings. Ask them to suggest the benefits of active listening:

1. The sender is really pleased to have the attention and be understood.
2. The sender does not feel that s/he is being judgmental.

TYPICAL TWELVE — DIRTY DOZEN — ROAD BLOCKS

1. Ordering directing, commanding. Telling the other person to do something — giving him/her an order or command.

2. Warning, admonishing, threatening. Telling the other person what consequences will occur if s/he does something; alluding to the use of your power.

3. Moralizing, preaching. Telling another person what s/he should or ought to do.

4. Advising, giving suggestions or solutions. Telling the other person how to solve a problem, giving him/her advice or suggestions, providing answers or solutions.

5. Lecturing, teaching, giving logical arguments. Trying to influence the other person with facts, counter-arguments, logic, information, or your own opinions.

6. Judging, criticizing, disagreeing, blaming. A negative judgment or evaluation of another person.

7. Praising, agreeing. Offering a positive evaluation or judgment.

8. Name-calling, ridiculing, shaming. Making the other person feel foolish.

9. Interpreting, analyzing, diagnosing. Telling a person what his/her motives are or analyzing why s/he is doing or saying something; communicating that you have him/her figured out or diagnosed.

10. Reassuring, sympathizing, consoling, supporting. Trying to make the other person feel better, talking him/her out of his/her feelings, trying to make his/her feelings go away, denying the strength of his/her feelings.

11. Probing, questioning, interrogating. Trying to find reasons, motives, causes; searching for more information to help you solve the problem.

12. Withdrawing, distracting, humoring. Trying to get the other person away from the problem; withdrawing from the problem yourself; distracting the person, kidding him/her out of his/her feelings, pushing the problem aside.

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3. The responsibility for the outcome remains with the sender. It cannot be shifted.
4. The sender either feels that s/he is understood or has the opportunity to correct any misunderstanding of his/her feelings.
5. The sender has a chance to express his/her feelings freely and feels better for it.

Group Counseling with Older People

Group counseling has come of age. It is regarded as an effective and economical counseling procedure, providing clients with support and stability while enhancing their personal growth and facilitating important change. For counseling older people, groups offer a milieu for useful and important interactions whereby their needs and problems can be realistically confronted. Groups have other significant advantages. They promote:

- social interaction among peers
- a cooperative and nurturing learning environment
- identification and sharing of special skills and knowledge of group members
- interpersonal growth
- creativity
- individual coping skills such as decision making, problem solving, and conflict resolution
- effective communication
- economical use of time and resources

Furthermore, groups replicate issues and behaviors found in other social settings. Many of these can be examined through the use of group activities such as role playing and simulations.

Groups have been defined and classified in various ways according to their structure and purpose. Detailed definitions and study of group theory can be found in literature. The aim here is to demonstrate how decision-making and life-planning groups, support and personal growth groups, and self-development and interpersonal relations groups can be used to serve the needs of older clients.

While this section emphasizes group counseling, many situations could be treated with either group or individual approaches. In some cases a combination of both proves most effective. The procedure selected should be contingent upon counselor's skills, client preference, and the amount and kinds of resources available.

Different types of groups differ largely in how they achieve their goals. The content or problem group members focus on may be legitimately addressed in any of the group-types presented. For example, the decision-making group selects preretirement as a topic of concern; its process is aimed at acquiring the skills necessary for making decisions and planning effectively. Support and personal growth groups would focus on the immediate intrapersonal needs, feelings, and anxieties that planning for retirement might evoke. A self-development and interpersonal relations group might provide special skill training needed by participants for successful preretirement planning—assertiveness training, communication skills, etc.

The following example shows how one group-counseling model or design (decision making and life planning) can be implemented to address issues pertinent to later adulthood (preretirement planning).

A series of issues pertinent to old age (which can be adequately addressed in any one of the three previously mentioned classifications of group counseling) will follow the abstract model and its expanded outline. Clearly other classifications of groups and models are available which can be similarly adapted to be used with older persons.

MODEL

Decision-Making and Life-Planning Groups

Purpose: To assist persons in the acquisition of skills which are necessary for making decisions and planning effectively.

Procedure: Group sessions can be planned to provide the following sequenced tasks:

1. Identify and define the target issue
2. Identify topics requiring decisions
3. Determine priorities
4. Gather information
5. Review priorities
6. Formulate alternatives for action

7. Evaluate and select alternative(s)
8. Plan for action
9. Evaluate action plan and decision. Establish time for periodical follow-up and evaluation.

Expanded Example

Group size: 6 to 20
Sample issue: Preretirement planning
Purpose: To assist persons in the acquisition of skills which are necessary for making decisions and planning effectively for retirement.
Procedure:

1. Identify and define target issue. Group Activity: Leader (counselor) introduces topic, gives broad definitions, solicits other meanings and perceptions from participants.

2. Identify topics requiring decisions. Group Activity: Brainstorming — participants suggest possible topics for consideration; leader suggests additional important topics. Group Activity: (30 minutes) Triads discuss topics generated and cluster related topics; each triad states these as objectives or questions. For example, How can I improve my financial management skills so that I can live comfortably on my income?

3. Determine priorities. Group Activity: Each participant rank orders the topics previously identified; the ranking is based on personal preference and need. This will form the basis for the remaining activities in this model.

4. Gather information. Group Activity: Participants may need to gather additional information about the topics which they previously selected for consideration. Group Activity: Administer tests for personal assessment, e.g., interest, aptitude, value. Group Activity: Participants review personal work and leisure time experiences, identify skills, knowledge, and resources. They are then grouped (3 or 4 to a group) to share lists, discuss importance of data, and determine what other information they will need.

5. Review priorities. Group Activity: Participants review and may re-rank topics, using the information gathered to guide their ranking. Each participant then restates the three most important topics so that they have personal meaning.

6. Formulate alternatives for action. Group Activity: Participants restate problem statements made in #2, e.g., "What can I do now to help me add to my income after I retire?" Participants air problem statements with the group. Those with similar statements are grouped into smaller task forces. Group Activity: Group statement — each task force is directed to help members to clarify and analyze problem statements by using a group interview format: each person is interviewed by members of the task force and asked to explain his/her statement and give reasons for its importance, e.g., "What do you mean by__________?" "Why did you select this problem?" "What was the most useful information about yourself that made you select this problem?" If necessary the group assists each person in redefining or developing a new statement or question.

7. Evaluate and select alternative(s). Group Activity: Assessing operational criteria, each participant presents a list of acceptable alternative statements to the group (Improve my hobby skills so that I can earn extra money by starting a part-time business after retirement). Group members analyze their own alternatives using the following criteria:

Criteria	Low				High
a. feasibility (is this a real choice: can it be done?)	1	2	3	4	5
b. practicality (what resources are needed to do this: financial, knowledge, skills, etc.?)	1	2	3	4	5
c. attainability (do I have or can I get the needed resources?)	1	2	3	4	5
d. predictability (can I predict outcome, e.g., high or low risk?)	1	2	3	4	5
e. acceptability (do I like this alternative?)	1	2	3	4	5

Group Activity: Each alternative is scored. The highest totals indicate the most desirable alternatives for action. Group Activity: Each member of the sub-group ranks the others' statements on the criteria listed above and renders this feedback to the other members.

8. Plan for action (carried out in sub-groups with similar interests). Group Activity: Group members cooperatively develop a plan for action that each person can follow. Determine (list) what they have to do, e.g., What do I need to know? Where can I get the information? Where can I get necessary training? How much will it cost? How much time will it take? How do I start when I'm ready? Within the group divide responsibilities for gathering the information.

9. Evaluate action plan and decision. Establish time for periodical follow-up and evaluation. Group Activity: Each person reports on the information s/he has gathered and the group then decides whether or not implementation seems possible. Periodic progress meetings are planned, so that the group can assist and support its members as needed.

Issues for Decision-Making and Life Planning Groups. Any problem or conflict that requires the individual to make choices is suitable content for decision-making and life-planning groups. While older adults experience problems similar to other individuals, there are generic issues more critically related to later life stages. Some content areas are: (1) pre-retirement and retirement counseling, (2) leisure planning, (3) employment or new career planning, (4) educational planning, and (5) residential planning. These topics and related issues will be briefly discussed.

Preretirement and Retirement Counseling. Most people have about fifteen years of life ahead of them when they reach the age of 65. Women have more years; men less. As care for the aging improves, these years will increase. What will they be like? How one lives them is certainly as important as how long.

Retirement is a fact of life today. Often it is joyfully anticipated; often, feared, ignored, or denied. Each of us can choose whether to plan for retirement living or just let it happen. Planning for retirement may be painful for some because it requires them to accept the reality of their own aging and their expendability in vital career roles. The individual who plans for retirement can move into the future with the confidence and satisfaction of having made choices based on personal needs, preferences, and resources. Although unable to predict the future with very much certainty, the individual who can confront change in her/himself is more apt to successfully cope with a changing world. It is possible and practical to plan and prepare for an enriched and stable life after retirement.

Preretirement planning has other positive effects as personal and financial resources are assessed: present preventive health care seems more valuable for those planning an active later life; financial planning takes on a different aura for those who anticipate a full post-retirement life style. (Realistically, preretirement counseling may also include plans for death and subsequent care for families: wills, burial arrangements, financial arrangements, etc.) The overall goal of pre-retirement counseling is to make the retirement years full, satisfying, and free from undue stress.

Retirement counseling may process topics and concerns similar to those in pre-retirement counseling, but there is usually more immediacy and urgency since the client is already experiencing a dramatic change in life style. In extreme cases retired clients may exhibit symptoms of retirement shock, and the counselor may need to provide individual counseling services. (Refer to Module V-B for more on retirement and pre-retirement.)

Retirement counseling can help individuals define their changed status in life. Decision-making and life-planning groups can also help focus on target issues and foster the skills needed to tackle developmental tasks. The retirees learn that even post-retirement life is not constant and that they must plan to accommodate the progressive aging process. The following are sample topics for pre-retirement and retirement groups.

— new roles or second careers
— leisure time activities
— housing options
— income maintenance
— health care planning
— identity or self-concept
— geographic relocation
— community service roles
— insurance programs
— legal services

Leisure Planning. Leisure activities add pleasure, satisfaction, and variety to our lives. Leisure time can be enhanced and enriched by adequate planning and decision making. The older adult is commonly confronted with extended blocks of free time that can be debilitating if passed in boredom, inactivity, and loneliness. On the other hand, the freedom available to older persons can be used to expand their life experiences if they are aware of and act on the range of options open to them.

Leisure activities chosen by older adults often reflect interests and skills developed throughout their life span. Older persons who have had active lives with varied interests usually have little difficulty planning for leisure time. They are more concerned with "planning for" than with "deciding what." But those who have devoted their adult lives almost exclusively to job and family may suddenly find themselves in a void; they may feel useless, unwanted, and uninteresting. The counselor can help these clients explore their interests, abilities, and preferences.

Effective leisure planning often proceeds from fantasy explorations, i.e., expression of former hopes, wishes, and dreams: "What have I always wanted to do but never could?" While fantasies are useful in generating creative plans, the actual decisions also need to be grounded in reality and based on the financial resources, physical condition, and mobility, etc. of the older client. These limit the older person's choices and determine which new experiences or interests can be integrated into his/her life. (Refer to Module V-B for a more in-depth treatment of leisure). The following are sample topics for leisure planning groups:

- identifying skills, interests, preferences
- setting priorities for using time
- choosing learning environments (public education, libraries, study groups, colleges or universities, television, church, and resource centers, etc.)
- generating income
- volunteer work and community service
- social involvement (how to use leisure time alone and with others)
- promoting creativity
- arranging for participation in activities (transportation, equipment, supplies, cost, etc.)
- recreation

Employment of Alternative Career Planning. Some older persons retire without withdrawing from the employment world or the job market. Many opt to change careers or continue with an adaptation of their existing employment because of life-style preferences, interests, or financial necessity. Pre-retirement planning often includes career decision making. Career planning can be effectively implemented in decision-making and life-planning groups because the sequential process and group sharing develop new skills and provide information and perspectives that enrich the formulation of realistic plans.

Career planning is especially advantageous for women who have not been employed outside the home. For reasons of financial need or personal fulfillment they may choose to leave the "empty nest" and add a new dimension to their lives. Women who contemplate re-entry to school or the labor market need to identify their skills and interests so that they can adapt and apply them to current job opportunities. Many of these women lack self-esteem and self-confidence and need to renew their sense of accomplishment and achievement in the outside world. The group experience gives them a chance to use the supportive environment, explore alternatives, make decisions, and plan for implementation. Below are sample topics for career planning groups:

- planning for change
- assessment of skills and interests
- values clarification
- orientation to the changing world of work
- analysis of job opportunities
- educational programs
- financial management
- employment problems and barriers
- legal rights — affirmative action, Title IX, etc.
- assuming new roles
- assertiveness training
- alternative career models
- starting one's own business
- organizational development and human relations training

Educational Planning. Education is the second largest "business" in this country, bowing only to national defense in total yearly expenditures. The fastest growing sector of the educational enterprise is adult or continuing education. Education has become a legitimate lifelong activity, and educational planning can be an exciting experience for the aging. Research indicates that the aging person retains the potential and capacity to continue learning and relearning, even though physiological changes may affect the style and rate of learning.

Older adults have been returning to school in enormous numbers through programs in public adult education, continuing education, vocational education, and traditional academic education. Many programs are subsidized so that older persons attend cost-free or quite inexpensively. Many offer training for new careers, retraining or updating of existing job skills, enrichment programs for leisure or personal growth, etc. There are noncredit experiences and credit courses at all academic levels, television and correspondence courses, and on-the-job training and individual study opportunities.

The many choices can be confusing. The adult who wishes to return to school may need guidance, support, information, and reassurance just as the adolescent leaving high school does. Many adults need to relearn "how to learn": study skills may be rusty, reading patterns may be slow or inefficient, anxiety may be high, and self-confidence low. It may seem inordinately risky to the older adult to return to school and face possible failure, embarrassment, and inadequacy in classes with younger people.

Educational planning with an older person requires a thorough analysis of skills, interests, and values. Counselors can help by interpreting information about various programs, courses, credentials, institutional procedures, scheduling, and requirements, etc. They can also help the client to realistically estimate the necessary time commitment and to formulate a sequential plan if the venture is career-goal directed.

The educational experience offers the opportunity to explore interests and abilities. Older clients need to recognize that they can make mistakes, change their minds, and revise or redirect some decisions. Older persons who accept this stance are freed from the threatening stigma of failure or dropping-out and will become more open to new learning and success. (See Module V-B for more information on Lifelong Learning.) Here are some suggested topics for educational planning groups.

- personal assessment — aptitude, achievement, values, interests
- vocational education and training
- higher education — academic entrance requirements, transfer credits, life-experience credit, program options, application and registration procedures, scheduling, costs, time required
- orientation to the interpersonal academic community
- study skills — reading, communications, testing, writing, research, library skills
- gathering information — catalogues, U.S. Department of Health, Education and Welfare, state departments of education, local boards of education, professional organizations
- career-oriented program planning — setting goals, determining needs, selecting educational resources
- exploration of the variety of available educational environments and experiences, traditional and non-traditional

Residential Planning. The life-style of the aged generally depends on where they live. The opportunities for social relationships, health services, recreation, transportation, employment, and education depend on the community and the type of housing in that community. Like other life choices, the quality and type of residence are selected by the older adult in response to physical health, financial resources, and personal values. Too often no deliberate, thoughtful planning is given to long-term living and the "choice" becomes the least objectionable crisis solution for older adults and their families.

For many social, economic, and political reasons (presented elsewhere in this syllabus), housing for the aging has been made a national and local priority. Many alternatives exist: retirement communities, retirement hotels, clubs, condominiums and co-ops, mobile homes, single-residential units, nursing homes, and the homes of children or other relatives.

Housing choices require precise planning and detailed information because they can involve a large financial investment, geographic relocation, changing familiar surroundings, upheaval in daily patterns of living, and establishing new social contacts. Much of the trauma associated with this anxiety-generating situation can be reduced and even deflected by good planning. (See Module V-B for more information about residential choices.) A list of possible topics for residential planning groups follows.

- type of facility — single or multiple residence, institution, retirement community, etc.
- geographic location — climate; cost; family and cohort accessibility; recreational, cultural, and educational resources
- services needed — health, transportation, diet, social, recreation, security, etc.
- employment or business opportunities
- financial investment and upkeep
- federal subsidies
- legal considerations
- values clarification

Support and Personal Growth Groups

Counselors of older adults are continuously confronted with the wide range of personal crises and concerns that clients and their families experience. The issues are as profound as death and isolation and as mundane as in-law relations and taxes. Regardless of the problem, the older person commonly feels alone, alienated, and lacking in self-confidence. Support and personal growth groups can provide an effective intervention technique for the aging and their families as they grope with vital problems. In these groups participants are encouraged to share strengths; explore common concerns; examine their basic beliefs and values; examine personal styles of relating to others; and reveal fears, anxieties, hurts, hopes, and resentments. Through the sharing process, participants become part of a cohesive social unit and recognize that they are not alone. The group process permits a pooling of the resources available to all its members; it encourages a climate of warmth and affection where group members become more responsive to the needs and values of others.

Support and personal growth groups mobilize group forces to help members as they struggle with personal crises. As the group develops, core group processes evolve. Gazda (1978) presented eight predictable core processes common to experiential groups. They are: (1) establishing and maintaining cohesiveness — group members develop a sense of belonging; (2) behaving in conformity with group norms — group members learn what is and what is not acceptable behavior; (3) consensual validation of personal perception and the use of feedback — group members learn to give and accept information about personal interactions; (4) expressing emotional immediacy — group members begin to share their immediate feelings and emotions; (5) group perception of problem relationships and input to problem solving — group members engage in cooperative problem solving as they recognize the advantages it offers; (6) expression of power and influence — group members learn to take leadership roles and to confront their own limiting responses to authority figures; (7) differentiation of roles — group members have the opportunity to try new roles and move out from former restraining behaviors; (8) intimate self-disclosure — group members develop trust, respect, and caring for others as they disclose personal concerns and feelings.

The development of the group as seen through these processes usually depends on the skill of the leader/facilitator. The group leader needs the skills to: (1) set and maintain a supportive accepting climate in the group; (2) clarify group and individual goals; (3) provide appropriate resources for attainment of goals; (4) interpret group dynamics and foster group and individual growth through effective interventions; (5) model behaviors that communicate acceptance, support, openness, and empathy.

While support and personal growth groups have many similarities, they may differ in their focal content. Support groups are organized around specifically stated issues, i.e., bereavement, dealing with terminal illness, sexuality, etc. The group activities are based on the following assumptions: (1) group members are "normal" people experiencing problems, (2) group members share a common concern, (3) they want to learn to cope with "the problem" more effectively, (4) they are willing to give as well as to accept help, (5) they want to make changes in their lives and in their relationships with others.

Another alternative for support groups is the Peer Counseling Model. Group functions are the same except the leader role, which is shared by members of the group as they cooperatively work to achieve their goals. It offers a practical option where counselor services are limited and can give older clients the opportunity to develop new skills and a new sense of independence. (See Module VIII.) Personal growth groups are similar to support groups in mission, assumptions about participants, and development of group processes. Not specifically focused on one target issue, they are open to any current needs or concerns of the group members. The leader role in personal growth groups involves a slightly less-structured approach necessary to promote flexibility and spontaneity in group activities. Any personal or social issue that impinges on the life of an older adult is appropriate content for support and personal growth groups. The counselor may need to encourage group members to explore their concerns, frustrations, and anxieties in order to identify and clarify common issues for group processing. Some examples of topics of support and personal growth groups are:

- preparatory counseling for death and dying
- loneliness, bereavement, and widowhood
- loss, isolation, and depression
- sex and sexuality

Preparatory Counseling for Death and Dying. A most significant developmental task for an older person is adjusting to the inevitability of his or her own death. Obviously persons of all ages die, but most deaths do occur in old age. Any older person must cope at least in the abstract with the reality of death. Support groups can be very helpful both for the older individual who wants to explore his/her own acceptance (or fears) of death and for the person whose mortality has been confirmed by the onset of a terminal illness. (The reader is referred to Module V-C for more on dying and death.) Death raises many issues which can be addressed as topics for preparatory counseling for death, dying, and living groups.

- discussing fears of death and/or dying
- discussing the significance of one's living
- self-awareness of the reality of personal death
- working through feelings (resentment, fear, etc.)
- putting things in order
- planning for the future (taking care of unfinished business)
- working on personal relationships with family and friends
- saying goodbyes

Loss, Isolation, and Depression: The use of reminiscence. The aged are subject to increasing amounts of stress: Many people dear to them die, they may suffer physical health loss, they can have mounting financial problems, society often denigrates them, they may become isolated from the mainstream of life, their self-esteem can often be damaged, and they may worry about a disabling catastrophe or abandonment. Depression can result if even a few of these conditions exist. The counselor of the aged must not accept the prevalent attitude that nothing can be done to treat depression in the aging. Reminiscence, the technique presented here, is only one of the myriad remedial and preventive approaches to normal depression in the aging. It can help make life meaningful and self-fulfilling in the later years.

When used in support groups, reminiscence can benefit older persons in many ways: First, memories of past achievements can improve self-esteem. The depressed person can explore past strengths by asking, "What have I done that has made me proud?' (Ebersole 1976). Second, reminiscing provides an opportunity to express anger toward society in a healthy fashion. The depressed elderly person who internalizes much of his/her anger can be encouraged to complain about younger generations that are not appreciative of the lessons to be learned from history and are making a mess of the world today (Ebersole 1976). Third, the repetition of painful memories can desensitize these memories. Finally, looking back to the loss of loved ones or trying times will often lead to a release of previously repressed emotions and tears. This is healthy for the grieving process.

Groups can employ reminiscence in various settings with well-functioning and generally adjusted members of senior citizen centers as well as with nursing home residents and elderly outpatients of mental hygiene clinics.

These groups present an opportunity for what Butler (1963) refers to as "life review." Going back to the past and placing the pieces together helps participants better appreciate the meaning of their lives. Sharing memories often has a socializing effect enhancing communication and developing an awareness of the worth of other members of the group. (See page 210 for an activity exemplifying the use of reminiscence).

Reminiscing works best with small groups of eight to ten persons (Burnside 1976). Pictures of holidays and special occasions displayed on peg boards can remind participants how such events were celebrated years ago. Memories can be stirred by old photographs of people or pastoral and urban scenes. Records of songs and bands popular in another era often bring back "The Good Old Days."

Reminiscing sessions can also be stimulated by showing an early silent movie or a series of old news clippings. Participants may want to bring early books, photograph albums, magazines, clothing, jewelry, and handicrafts to group meetings. Counselors are cautioned, however, to avoid probing, confrontation, and interpretation in this technique (Ebersole 1976).

Reminiscence can also be helpful on a one-to-one counselor-counselee basis. If the counselor also reminisces, the commonality of past experiences and the self-disclosure of the counselor as a person can strengthen the relationship. The counselee may come to see age as an enhancement in the eyes of the counselor. This factor is especially significant for aging clients who look on counseling as degrading.

Sensitizing others to the worth of reminiscence should be an important task of the counselor. Reminiscence is more often a form of communication and a means to develop relationships than a counseling technique. Encourage grandchildren to ask about their roots and what it was like in the "old country" or in the United States when they were children. Invite the elderly to show their memorabilia, old pictures of their family and of places they visited as well as treasured pins, jewelry, and trophies. These activities should be equally rewarding for the aging and for those listeners who truly love history and people.

Some topics for loss, isolation, and depression groups might be:

- discussing feelings and how the feelings happened
- discussing loss and feelings associated with it
- discussing kinds of losses (health, economic, attitudinal)
- normal depression vs. pathological depression
- improving self-esteem
- focus on the here and now (what is the actual situation?)
- focus on the future (what are the changes which can be made?)

Loneliness, Bereavement and Widowhood. In advancing years, loneliness, bereavement and widowhood are often interrelated. Besides the loss of spouse, close friends, and relatives, most retired persons no longer have casual office or shop talk. Poor health becomes confining and ventures beyond the home difficult. Limited finances, fear of attack, and the negative attitude of society also contribute to abandonment and isolation for a large part of the older population.

Counselors must be sensitive and sensitize others to the lonely world of many of the aging. Probably few counselors-in-training have experienced staying home ill day after day without phone calls, visits from friends, or purposeful activity.

The counselor can play an important role in helping the aging cope with loss and loneliness. Active intervention may be necessary to support those who accept loss and loneliness as a way of life and believe there is no release from suffering. (See Module V-C for more information on survivorship.) Some topics for loneliness, bereavement, and widowhood groups might include:

- discussing feelings of loneliness, fear, etc.
- assessing needs — emotional, physical, economic, etc.
- taking care of the paper work (funeral arrangements, insurance, etc.)
- practical problem solving (information-giving sessions on financial assistance available, social security benefits, community agencies serving the bereaved, etc.)
- grief (discussing the importance of a period of grieving and associated normative behavior)
- discussing options for the living (relocation, employment, etc.)
- reinvolvement with the living
- carrying on — referral to new groups (i.e., widows who will be reentering the job market may be referred to a career counseling group)

Sex and Sexuality. Despite lip service to the desirability of dealing with this subject, many counselors avoid it and few courses on counseling the aged include sex. The often held notion that sources of help should be limited to highly qualified sex therapists is not beneficial to older persons, who often need only relatively simple information, reassurance, and a chance to discuss sex matters in an understanding and supportive atmosphere. Specially oriented support groups might be helpful to them.

Counselors of the aged also need to do missionary work to dispel the many myths about sex in later adulthood. Sexual life during older age can be satisfying and rewarding, but questions about sexuality that are left unanswered can lead to feelings of depression, anxiety, and guilt. The desire for sexual relations is a natural response at any age, and sexual relations can remain a natural function into the eighties and beyond.

Counselors should know about the physiology and psychology of all the stages of adult sexual development and be comfortable with their own sexuality and with discussing sex with others. There are varied sex drives and behaviors among the older population just as with other adults. The aging should be allowed to enjoy sex with dignity. If they are not interested sexually, their counselors must not implant doubts or feelings of inadequacy in them. Study and consideration should also be given to the varied sex needs and problems of all older people, including older homosexuals.

Older people with sex problems should be treated like anyone else with sex problems. If younger people are allowed sexual relationships outside of marriage, it is unreasonable to impose a different standard on older people. Sex need not be limited to sexual intercourse. Masturbation may be a desirable practice since it is one of the few sexual expressions available to some, particularly older women, who greatly outnumber living males in their age group and may be limited in their choice of partners.

Sexuality in its broad sense can also be very satisfying. Intimacy, bodily contact, romantic situations, and affection are enough, in many instances, to fulfill individual sexual desires. Some topics for sex and sexuality groups may include:

- anxiety
- availability or lack of partners
- normal physiological changes
- myths associated with aging and sexuality

Self-Development and Interpersonal Relations Groups

Self-development and interpersonal relations groups can be viewed as extensions of support and personal-growth groups. While both types provide opportunities for growth, they differ in purpose and process. Self-development and interpersonal relations groups generally focus on specific topics and skills; group goals are defined in relation to the stated topic, and group sessions are structured to provide participants with learning experiences aimed at the acquisition of special information and skills. Examples of these groups are: assertiveness training, leadership training, improving communication, coping with marriage and/or divorce, effective grandparenting, intercultural and interracial awareness, relaxation and anxiety reduction skills, weight and/or diet control, smoking, drug, and/or alcohol control, etc. (Only four of these types of groups are discussed here.)

Like support and personal growth groups, these skill-oriented groups require a nurturing climate that facilitates openness, trust, and caring among participants and that establishes a protective milieu where group members can learn and experiment with new and often risky behaviors. Not only is learning enhanced by an accepting environment, but peer support and feedback encourages group members to integrate new skills into their present behavioral repertoire and to become more effective in coping with their problems.

Self-development and interpersonal relations groups are enormously useful in counseling the aging for they offer many gains in addition to the expressed topical goals. The most obvious side-benefits of these groups are the opportunities for social interaction, the general sense of increased vitality that often accompanies the mastery of new skills, renewed motivation to continue the learning process and extend it in various directions, and other similar responses that contribute to the self-actualization process.

The success of self-development and interpersonal relations groups depends on the knowledge and skill of the leader. Since these groups address specific topics and aim at promoting specialized learning, the leader must be sensitive to individual needs and learning styles in order to blend them with appropriate learning tasks. The counselor-leader in these groups plays a directive role and is role model, resource person, facilitator, and teacher.

Since, the purpose of these groups is the development of special coping skills, suitable topics incorporate some type of specific skill or knowledge that can be taught, demonstrated, and practiced in group sessions. Examples of these are:

- assertiveness training
- residential housing
- marriage or couple counseling
- intergenerational or extended-family counseling

Assertive Training. Helping older adults improve their quality of life presents an extraordinary challenge to counselors. Aging clients often feel lonely, depressed, dependent, and powerless to change the events in their lives which may reinforce these feelings. Others who may have a more positive sense-of-self are often tyrannized by stereotyped social attitudes and expectations regarding "the elderly."

Assertive training is a valuable way to help older adults develop more effective interpersonal skills and coping behaviors. Using systematic skill-building experiences, counselors can assist aging clients to become more confident in expressing their needs and preferences, more assured in assuming day to day responsibilities, and more effective in establishing approach behaviors toward others. All of these serve to make life experiences richer and more satisfying for the older person. Some topics for assertive training groups include:

- exploration of personal strengths
- self-diagnosis and learning needs
- exploring feelings related to assertive and nonassertive behaviors
- behaviors that ignore or block (your) assertiveness
- difference between assertive, aggressive, submissive and hostile responses

Residential Housing Groups. Retirement villages, senior housing units, and various forms of communal living (including sharing one's home with others) can give joy and enhace life for the aging. These groups can also be filled with interpersonal strife that results in bitterness and discontent.

Self-development and interpersonal relations groups that apply specifically to group living arrangements for older adults can center on common problems: "How can I maintain a sense of privacy without alienating myself from fellow residents?" "My neighbor constantly calls me and consumes an overabundance of my time. Is it possible to protect myself from this incessant draining of my energies? Can I be helpful to her at the same time?" Questions like these vary with each group. They do not require cook book answers, but can be used to teach the procedures of problem-solving, interpersonal communication skills, and assertive training. The following are suggested topics and issues:

- governance models
- support groups within the housing community
- rights and responsibilities of tenants
- procedures for making changes
- development of positive ways to relate to others

Marriage or Couple Counseling. Close relationships are not static. A partner's interests and needs will change. In the later years of life s/he will most likely lose some roles, use remaining roles more fully and perhaps add some. The recently employed, now retired worker will have more time with his/her spouse. They may discover that family activities are no longer centered around them, and that they have too much time without purpose. On the other hand, one may wish to continue the daily activities of at least the past several years without significant changes. Far from the envisioned joy of the constant companionship of the retired partner, the reality seems often to result in boredom, anger, and frustration. One may wish the other would help more with household duties, which may be considered menial and unappreciated tasks.

Second marriages in later life frequently take on unique dimensions. Each partner may have a memory or an idealization of a previous marriage or close relationship and compare this present relationship unfavorably. An important factor that may contribute to an unhappy marriage in later life is the poor health of the husband or wife. The marriage may have originally been intended to provide companionship or financial security. Instead, one of the partners develops a chronic illness and the other finds money is now a problem and freedom of movement impaired. Resentment and anger often result.

Other topics and issues for marriage or couple counseling might include:

- marriage enrichment
- role changes
- redefinition of the relationship
- the value of time together and time to oneself
- the effects of poor health of one or both partners

Intergenerational or Extended Family Counseling. When older adults and their families are encouraged to examine and discuss their feelings, they will frequently focus on intergenerational problems, showing signs of hostility, guilt, frustration, and ambivalence. Counselors and older clients will benefit from understanding the commonality of many of these intergenerational problems and how the welfare of aging parents is markedly affected by their children's often repressed feelings and attitudes. Counselors must understand their own emotional reactions and what might facilitate or interfere with their success not only in counseling older persons but their own family relationships.

The roots of intergenerational conflict are frequently deep-seated and span many years. The development problems that sometimes occur with aging, particularly poor health and financial difficulties, may cause or increase strain on the family relationship.

Older adults may wish to discuss their feelings about the neglect of their children, the interference with their independence, the regret at being "a burden," the lack of respect from grandchildren, etc. On the other hand, their children often wish to vent their annoyance with the "unreasonable demands," the interference in the management of personal affairs, and the hurts dating from childhood. Effective communication, assertiveness, and problem solving are all useful in intergenerational or family counseling. Counselors will have to determine whether to meet with generations of the extended family separately. It is often helpful to meet first with the older adults and their significant others in different support groups and then with the family together. Some topics and issues that might be discussed are:

- long-standing family conflicts
- role expectations
- independence vs. healthy dependence and assistance
- communication skills

Body and Creative Therapies

For older adults, body and creative therapies are attractive alternatives to verbal counseling techniques. They can be productive for the counselor and the aging client by providing experiences that acknowledge and encourage creativity and expressiveness while fostering openness. Art, music, movement, and body therapies can improve spontaneity and growth through the fullest expression of the mind and body. They are particularly effective with the older adult because they confront at least two important issues pertinent to counselors for this age group. First, older adults may associate counseling with mental and emotional dysfunction, mental illness, or pathology, and may reject counseling as a sign of weakness, helplessness, and loss of privacy. These historical attitudes and biases are real communication blocks between the counselor and the client. Second, the aging person who has experienced physiological changes affecting body motility, sensory awareness, stamina, and general physical and emotional response patterns can easily become resigned to an inactive physical and mental life. Through art, music, movement, and body therapies, older adults can overcome negative attitudes toward counseling and toward aging and can participate in activities that help them live in the fullest possible manner.

One type of therapy is Bioenergetics. Alexander Lowen, primary developer of Bioenergetics, states that "Bioenergetics is a therapeutic technique to help a person get back together with his body and to help him enjoy to the fullest degree possible the life of the body." Bioenergetics strives to increase the energy level of the individual through breathing and body exercises aimed at relieving chronic muscular tension in the body. These tensions "disturb emotional health by decreasing an individual's energy, restricting mobility, and limiting his self-expression." In this approach, emotional well-being is addressed through integrating mind and body, recognizing that the body reflects psychological and emotional blocks and the fully functioning person needs to attend to the well-being of both. Bioenergetics is effective as a preventive, developmental, and remedial therapy. It provides older individuals with an awareness of body-mind integration and sets forth a way of living in the body that increases pleasure and joy of living through aliveness and spontaneity.

Bioenergetics or other body and creative therapies require special training and skilled, sensitive application. Misuse or unskilled application could be harmful to aging clients with certain body problems or complex psychological problems. Counselors need to be aware of the potential these models have for working with older adults so that they can make knowledgeable referrals for client treatment and/or pursue special training programs for their own professional and personal enrichment.

Specialized Techniques for Working with the Disoriented

"Unless one knows who s/he is, where s/he is, who the people around him/her are and has some idea of time, s/he cannot function as a person" (Folsom 1975). The process of counseling may be considerably different for the small portion of the aging population that is disoriented. For problem solving and understanding one's feelings and attitudes, orientation to one's environment is essential.

Several therapies or techniques have improved the lives of patients in nursing homes and mental institutions by increasing their awareness of self and surroundings. Counselors who are to work with disoriented persons should know these techniques and become competent in their application. With the permission of the Gerontological Society, the following article (next page) describing and comparing modalities for treatment approaches used with older people is included.

The Continuing Education Program of the Gerontological Society, through its grant and its contract from the Continuing Education Branch of NIMH, is pleased to present the following paper. We believe this compilation of a broad range of mental health treatment modalities will be a useful aid to in-service education and staff development programs.[1]

Marvin S. Schreiber[2] and Barbara Herzog[3]

Guidelines to Treatment Approaches

Modalities and Methods for Use with the Aged

Eleanor K. Barns, OTR, MA, Ann Sack, MA,
and Herbert Shore, EdD[4]

Modern medical institutions have been faced with large and increasing numbers of aged individuals, particularly those with chronic and mental disabilities. Social and cultural attitudes toward the aged as a group have been principal obstacles to improving the care and rehabilitation of the aged person. The attitudes of the medical profession and of the lay public have differed little, although the rationale of the former has been somewhat better formulated. Physicians have noted the low level of effectiveness of the usual methods of treatment and rehabilitation of the aged and have admitted the limitations of ability to reverse the aging processes. The shortage of physicians and other skilled professionals specially prepared to cope with the problems of the aged has been evident, and the wisdom in allocating costly resources to patients who are unlikely to improve has been questioned.

Allison (1961) in *The Senile Brain* states,

> Whatever may be said in favor of it, old age is a losing game. We must, therefore, focus attention upon the ways and means of ensuring that points in the game are not given away unnecessarily.

There is a popular poster that says, "Not to decide is to decide." The implications of this are clear. The absence of a treatment program is a treatment program, be it custodial, warehousing, or containment.

In working with the mentally impaired aged, three conditions are recognizable, although they may not always exist independently. There are: mind lack, mind twist, and mind loss. Mind lack is commonly characterized by the mentally retarded or mentally deficient. Mind twist covers those mental, psychological, or psychiatric disorders in the behavioral sphere commonly classified as neurosis and psychosis. Mind loss is that process of impaired functioning in which the individual may have functioned and behaved normally until the aging changes make the individual function less effectively.

Dictionary of Symptoms

The majority of patients in long-term care institutions generally have three basic problems, regardless of diagnosis. These are: lack of self-confidence, social withdrawal, and difficulty in interpersonal relationships. In addition, older people in long-term care institutions have been observed to be suffering from cognitive, emotional, and physical impairments associated with senile mental deterioration. The symptoms associated with these conditions usually are (Sandoz, 1973):

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[1] Individual and bulk copies may be ordered at 50c a copy, prepaid, with a 10% discount on 20 or more copies, from the Gerontological Society, #1 Dupont Circle, Washington 20036.

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Anorexia: Loss of appetite, disinclination for food, inadequate intake, necessity for dietary supplements, loss of weight, change in attitude toward eating.

Anxiety: Worry, apprehension, overconcern for present and future, fears, complaints of functional somatic symptoms including headaches, dry mouth, trembling, sighing, sweating.

Bothersome: Frequent unnecessary requests for advice or assistance, interference with others, restlessness.

Confusion: Lack of proper association for surroundings, person and time; "not with it." Slowing of thought processes and impaired comprehension, recognition and performance; disorganization. Inappropriate response and behavior, including perseveration.

Depression: Dejected, despondent, helpless, hopeless, preoccupation with defeat or neglect by family and friends, hyperchondrical concern, persistent functional complaints, early waking.

Disorientation: Diminished awareness of place and time and identification of persons including self.

Dizziness: In addition to true vertigo, dizziness including spells of uncertainty of movement and balance, subjective sensations in the head, apart from pain as represented by light-headedness.

Emotional liability: Instability and inappropriateness of emotional response as illustrated by laughing or crying or other undue positive or negative response to non-provoking situations.

Faulty recent memory: Reduction in ability to recall events and actions of significance to patient such as visits by family members, content of meals, environmental changes, personal activities.

Hostility: Verbal aggressiveness, animosity, contempt, mocking, threshold to aggravation, stress, or challenging situations.

Impaired judgment: Reduction of mental alertness and attentiveness, concentration, responsiveness, alacrity and clarity of thought and actions, impaired judgment and ability to make decisions.

Indifference: Lack of interest in everyday events, pastimes and environment or surroundings, where previously existed oftentimes in areas of news, TV, heat, cold, noise.

Irritability: Edgy, cantankerous, easily frustrated, low tolerance threshold to aggravation, stress or challenging situations.

Motivation-initiative: Lack of spontaneous interest in initiating or completing tasks, routine duties and attending to individual needs.

Self-care: Impairment of ability to attend to personal hygiene; dressing, grooming, eating and getting about, bathing, toileting.

Uncooperativeness: Poor compliance with instructions or requests for participation. Performance with ill grace, resentment, or lack of concern and consideration for others.

Undue fatigue: Sluggish, listless, tired, weary, worn out, "bushed."

Unsociability: Poor interpersonal relationships, unfriendly negative reaction to social and communal recreational activities. Indifferent and aloof.

A variety of treatment techniques, modalities, methods, and therapies have been developed and used to assist the older person who exhibits mind loss and cognitive emotional impairment to break the Spiral of Senility (Fig. 1). Some are more effective than others. Some are easier to learn and some appear easier to use. The success or

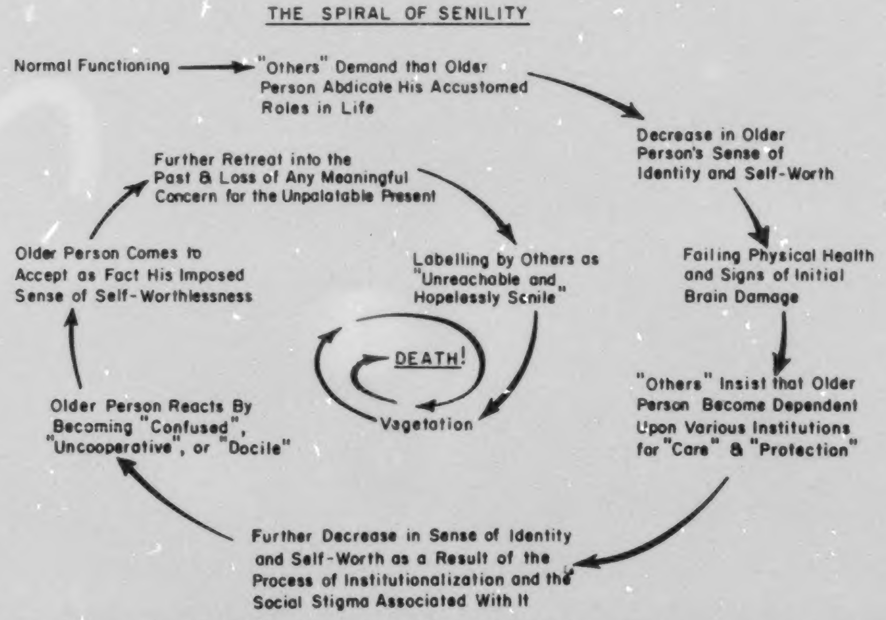
THE SPIRAL OF SENILITY
Normal Functioning
"Others" Demand that Older Person Abdicate His Accustomed Roles in Life
Decrease in Older Person's Sense of Identity and Self-Worth
Failing Physical Health and Signs of Initial Brain Damage
"Others" Insist that Older Person Become Dependent Upon Various Institutions for "Care" & "Protection"
Further Decrease in Sense of Identity and Self-Worth as a Result of the Process of Institutionalization and the Social Stigma Associated With It
Older Person Reacts By Becoming "Confused", "Uncooperative", or "Docile"
Older Person Comes to Accept as Fact His Imposed Sense of Self-Worthlessness
Further Retreat into the Past & Loss of Any Meaningful Concern for the Unpalatable Present
Labelling by Others as "Unreachable and Hopelessly Senile"
Vegetation
DEATH!

Fig. 1. It will be observed that "failing physical health" and "brain damage" may occur in varying degrees at any point along the spiral. Should these occur, it only hastens the spiraling process which, if continued unabated, leads to vegetation and death, although death itself may intervene at any point.

failure of any given approach is dependent upon a number of variables which include administrative philosophy, team concepts, and degree of pathology in the population. No single variable can be considered the determining factor.

The desire to bring about improvement in patient care is an essential catalyst for change as it stimulates interest in the patient, better communication by staff, and increased interpersonal relationships. The label of the modality is less important than the ingredients. However, in the supermarket of social and psychological approaches, one may wander the aisles and select a wide variety of treatments: behavior modifications, operant conditionings, milieu therapy, remotivation, reality orientation, reality therapy, token economy, to name a few.

What are the aims of these approaches? What are the differences? What materials and resources do you need? How does it work? Who can do it?—are questions often asked. It is the aim of this paper to present in a brief, useful form, a review of the major treatment approaches used in long-term care facilities, and, in doing so, to encourage centers to select and use a therapeutic model as an umbrella approach.

In long-term care facilities, emphasis in the past has been placed on meeting the basic physical needs of the patient. Providing clothing, food, shelter, and religious services had been considered adequate in the total treatment program, with the philosophy geared to the concept of custodial care. In recent years a new concept or philosophy has begun to emerge. New theories have been formulated about the aging process and the social and emotional problem of the older person. Changes in the health field concerning the older person have presented new and greater challenges to the field of medical rehabilitation. Attention focused on the traditional therapy processes has increased dramatically over the last few years. The evidence supporting the value of the different therapies has been increasingly impressive, and the thoughts and practice of many professionals are being affected by them. However, new models of treatment for the aged chronically ill and mentally impaired are needed. To help meet this need this material has been prepared.

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Reality Orientation

Reality orientation is a basic technique effective in the rehabilitation of elderly persons having a moderate to severe degree of memory loss, confusion, and time-place-person disorientation. This technique was initiated in 1958 at Winter Veterans Administration Hospital in Topeka, Kansas, by Dr. James Folsom and was refined in 1965 at the Veteran's Administration Hospital in Tuscaloosa, Alabama.

Reality Orientation is suitable for use in homes for aged, nursing homes, and psychiatric hospitals. It should be used at all times by everyone who has contact with elderly patients, including nursing assistants, housekeepers and porters, dietary workers, professionals from all disciplines, volunteers, and family members. Reality Orientation should begin to be used as soon as the first signs of confusion are noticed following a stroke or any major loss or change.

The backbone of Reality Orientation is the repetition and learning of basic information such as the patient's name, the place, the time of day, day of the week and date, the next meal, time of bath. This essential repetition and relearning is conducted both formally and informally.

Formal Reality Orientation classes should be conducted at the same time every day by a nursing assistant, housekeeper, or other person having close, frequent contact with the patients. During class the instructor should drill the patients on the essential information—name, date, place, time.

Informal Reality Orientation is conducted on a 24-hour basis and is crucial to the success of the program. Here, too, it is important that all persons having contact with the patients constantly stimulate them by repeating the essential information. Comments such as, "It's 3:00 in the morning, Mrs. Jones. Are you having trouble sleeping?" or "It's 11:30, Mrs. Smith. It's time to get ready for lunch." are not only polite, but also critical in reorienting the individual. These statements tell who he is, where he is, and what the appropriate activity should be.

Two additional techniques, Attitude Therapy and Remotivation, are also employed. Attitude Therapy is often used in conjunction with Reality Orientation, while Remotivation should begin as soon as the patient has successfully completed Reality Orientation. Both are discussed later as separate entities and are compared in Table 1.

Equipment

The following audio-visual aids are useful for both Reality Orientation classes and 24-hour Reality Orientation.

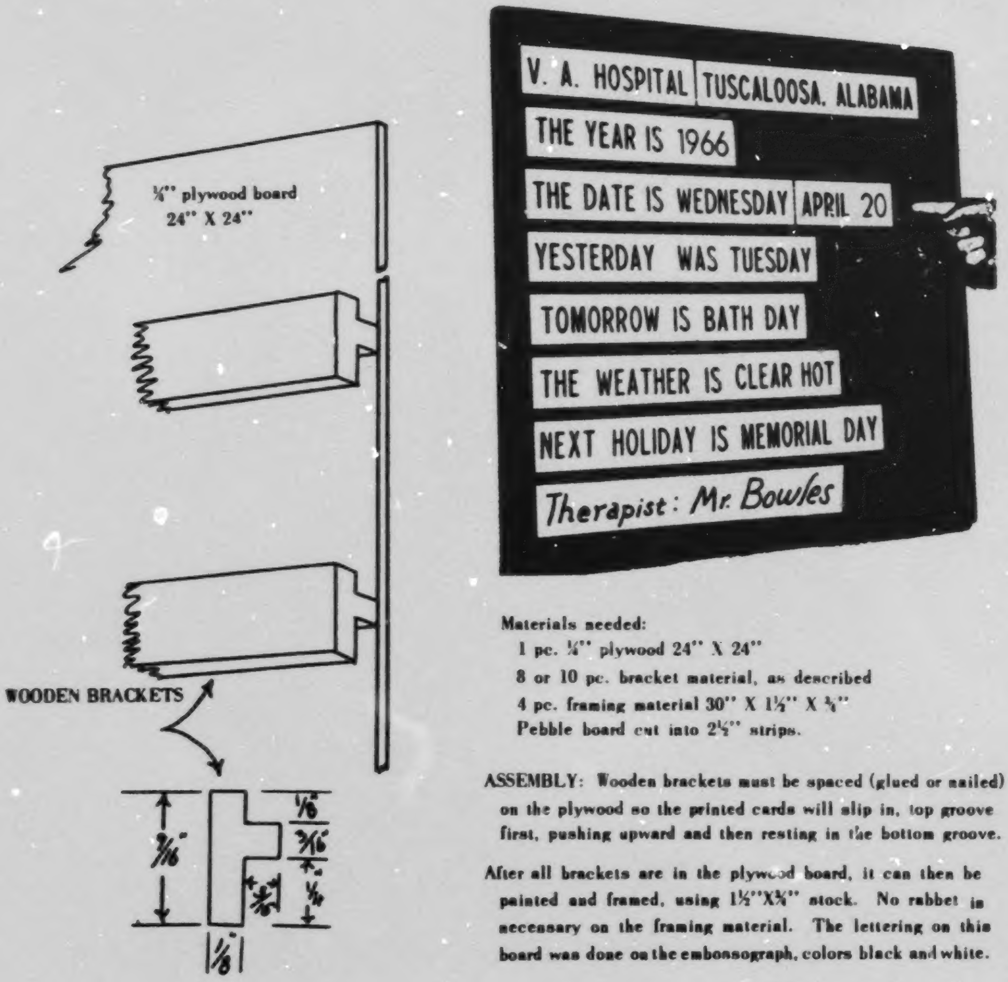
(1) *Reality Board* (Fig. 2). Reality Boards should be prominently displayed at nursing stations, dining areas, day rooms, and wherever patients spend their time. The boards should be changed as often as necessary and the day of the week and date, the place, the weather, the next meal, the next holiday, the next activity, the next bath, should be maintained.

(2) Large-face clocks or mock-up clocks for instruction telling time are useful.

(3) Brightly colored pictures of food are conducive to reorientation.

Reality Orientation Board

Leland C. Bowles, OCCUPATIONAL THERAPIST


¼" plywood board
24" X 24"
WOODEN BRACKETS
1/8
3/16
1/4
9/16
1/8
1/8
V. A. HOSPITAL
TUSCALOOSA, ALABAMA
THE YEAR IS 1966
THE DATE IS WEDNESDAY
APRIL 20
YESTERDAY WAS TUESDAY
TOMORROW IS BATH DAY
THE WEATHER IS CLEAR HOT
NEXT HOLIDAY IS MEMORIAL DAY
Therapist: Mr. Bowles

Materials needed:
1 pc. ¼" plywood 24" X 24"
8 or 10 pc. bracket material, as described
4 pc. framing material 30" X 1½" X ¾"
Pebble board cut into 2½" strips.

ASSEMBLY: Wooden brackets must be spaced (glued or nailed) on the plywood so the printed cards will slip in, top groove first, pushing upward and then resting in the bottom groove.

After all brackets are in the plywood board, it can then be painted and framed, using 1½"X¾" stock. No rabbet is necessary on the framing material. The lettering on this board was done on the embossograph, colors black and white.

Designed and made in PMRS, VA
Hospital, Tuscaloosa, Alabama

Fig. 2. Reality board.

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Personnel and Training

Every person who has contact with the patients should know the basic techniques of Reality Orientation. Five-day seminars teaching these techniques are offered through the Veterans Administration Hospital in Tuscaloosa. For further information, contact Mrs. Dorothy Scarbrough, Reality Orientation Training Program, Veterans Administration Hospital, Tuscaloosa, 35401. Phone area code 205-553-3760, extension 295.

References

Barker, H. R., Jr., & Smith, B. J. **Influence of a reality orientation training program on the attitudes of trainees toward the elderly.** Tuscaloosa: Alabama Regional Medical Program: Reality Orientation Training Project, VA Hospital, 1970.

Folsom, J. O. Reality orientation for the elderly mental patients. **Journal of Geriatric Psychiatry,** 1968, **1,** 291-307.

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Taulbee, L. R., & Folsom, J. C. Reality orientation for geriatric patients. **Hospital & Community Psychiatry,** 1966, **17,** 133-135.

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VA Hospital, Tuscaloosa. **Nursing service, guide for reality orientation,** rev. Feb., 1970.

Resocialization

Resocialization is a structured program involving patients in a geriatric setting, using group techniques to both expand consciousness and also broaden the recognition of available choices in their living community. The prime group goals are to: (1) stress interpersonal relations; (2) help the patient renew interest in the world he lives in by focusing attention on simple objective features of everyday life that are unrelated to emotional difficulties; (3) help the patient to reach into the past and give of himself once again.

The core of group resocialization is based on the premise that the principal obstacle in the development of acceptable socialization patterns is to be found in the orientation toward authority and intimacy which each member brings to the group. Patients can establish fresh relationships and form friendships; chronic complainers can find new interests; the agitated can be distracted. The program can help an older person retain or regain his desire to live by exposing him regularly to the kinds of experiences which give any person the feeling that life is worth while. Greater awareness of surroundings, values, and contributions can be realized, and an interest in the beauties of old age can be experienced. Resocialization is the catalyst to a shared experience which produces communication out of isolated individuals.

It is paramount for group members to begin to focus upon relationships to each other, the problems of living in a community, and the reliving of happy experiences. The leader provides a model for behavior by his activity in the group, his acceptance of the group members, his non-evaluative comments, his willingness to deviate from planned programs, and his ability to raise questions. By his own behavior, he aids in establishing an atmosphere of acceptance and freedom of expression whereby the group is enabled to discuss interpersonal problems that otherwise might be unsolved.

Equipment

Resocialization requires no special equipment. Refreshments are served in the group and the group leader is responsible for suggestions to supplement the activities of the group.

Personnel and Training

All staff members should be made aware of the role of the patient in a resocialization program. Any staff member can be a group leader in resocialization. However, the group leader—if not a professionally trained person in the techniques of group dynamics—should be under such direction and supervision. For further information on Resocialization contact St. Joseph's Manor in Trumbull, Conn.

References

Bion, W. R. Experiences in groups. I. **Human relations,** 1948, **1.**

Cartwright, D., & Zander, A. **Group dynamics.** Evanston, Ill: Row Peterson, 1953; London: Tavistock, 1954.

Kunkel, S. Resocialization: A technique that combats loneliness. **Nursing Homes,** 1970, **19** (8), 12-13.

Kunkel, S., & Sr. Brian (O.Carm.) Resocialization: A challenge in geriatric nursing. **Catholic Charities,** 1969, April, 4.

Remotivation

Remotivation is a technique to encourage the moderately confused elderly patient to take a renewed interest in his surroundings by focusing his attention on the simple, objective features of everyday life that are unrelated to the patient's emotional difficulties. Remotivation is intended to augment the other therapies and not to replace them. Remotivation is begun following successful completion of Reality Orientation.

Remotivation was originated by an English teacher, Dorothy Hosking Smith, an experienced mental hospital volunteer who served in veterans' institutions. Remotivation was first consciously used in the Philadelphia State Hospital in 1956 and has since been used in over 200 homes for the aged, public and private mental hospitals, and schools for the retarded. When Remotivation began to develop, the thought was that the remotivators would be social workers, nurses, psychologists, and other professional therapists. Hospitals, however, began using non-professional workers. There was value in giving this responsibility to attendants, aides, and other non-professional people, since these people saw the patients more than the professionals and were, therefore, more aware of the ward climate.

Remotivation is essentially a technique of simple interaction between a remotivator and a group of patients. There are two important therapeutic aims: (1) to stimulate patients into thinking about and discussing topics associated with the real world; (2) to assist patients to relate to and communicate with other persons. A Remotivation meeting consists of a group of 5 to 12 patients, who meet once a week for about an hour to discuss a specific topic chosen to motivate the group's interest and participation. A Remotivation series consists of one meeting each week for 12 weeks. In turn, each meeting is conducted through five successive steps or stages geared to motivate group interaction and conversation. This procedure includes:

(1) *The climate of acceptance.*—The leader introduces himself and welcomes each group member individually by name. This climate of acceptance can be enhanced by comments about the weather, the nice appearance of some member, or any other appropriate, objective, pleasant topic. (5 min.).

(2) *A bridge to reality.*—This step starts the group thinking about a selected topic of the real world and helps the participants to externalize and focus their interests upon the world in which they live. Several approaches are used to accomplish this step. These include: (a) the bounce question, (b) poetry (c) visual aids. Joyce Kilmer's *Trees*, for example, is soothing for listening. It also leads easily into a discussion of Spring, birds building nests, and similar things the patients can observe from their windows. Well-known quotations, articles from newspaper and magazines, or similar items can also be used. The leader should encourage individual patients to read portions of the poem or story and to participate in the discussion. (15 min.).

(3) *Sharing the world we live in.*—The purpose of this step is to elaborate upon and promote discussion in a specific direction. This is accomplished by 10 to 12 objective questions prepared in advance by the remotivator to serve to keep the group on the track and eliminate the tendency to diverge from the topic. These questions may stem logically from the topic in the Bridge to Reality or may probe a totally different subject. Visual aids serve as important stimulants in this step, and at least two visual aids should be used during each meeting. Colorful photographs and pictures help to focus the members' attention upon the main idea being exhibited. Other types of visual aids, such as cloth, dress patterns, and tape measures, can be used in the discussion of sewing. As the visual aid is being examined, the remotivator stimulates discussion by asking questions about it. (15 min.).

(4) *Appreciation of the work of the world.*—This fourth step is aimed to stimulate the patient into thinking about work in relation to himself. A discussion of the jobs and tasks that patients used to perform is especially useful in working with older persons. Individually tailored crafts and work activities, like those produced in an Occupational Therapy Department, both as a group and within the group, are also helpful in creating a meaningful appreciation of the world for older patients. (15 min.).

(5) *The climate of acceptance.*—The fifth step has the main purpose for the remotivator to express his appreciation to the patients for attending and participating in the meeting. At this time, the remotivator summarizes the high points of the discussion and announces the time and date of the next meeting to provide a sense of continuity and expectation. (5 min.).

Equipment, Personnel, and Training

Visual aids, colorful photographs and pictures pertaining to the subject, books of poetry and quotations, articles and anecdotes from magazines and newspapers, and any related items to subjects being discussed are useful.

A remotivator may be a nursing assistant or aide who has satisfactorily completed the basic program. In order to assume the role of remotivator, one must become a leader and be patient in manner. There are major responsibilities the remotivator must take. These include: (1) selection and structure of a group, (2) topic selection, (3) preparation for meeting (the meeting plan), (4) scheduling the meeting, (5) conducting the meeting, and (6) observation and evaluation.

For further information about the techniques of Remotivation, including a 30-hour course on the fundamentals of Remotivation, write to American Psychiatric Assn., Smith Kline & French Remotivation Project, 700 18 St., NW, Washington 20009.

References

Remotivation Training Centers

National Training Center, Philadelphia State Hospital, Philadelphia

Regional Centers

Patton State Hospital, Patton, CA
Colorado State Hospital, Pueblo
Norwich Hospital, Norwich, CT
Milledgeville State Hospital, Milledgeville, GA
Moose Lake State Hospital, Moose Lake, MN
State Hospital North, Orofino, ID
Osawatomie State Hospital, Osawatomie, KS
Western State Hospital, Hopkinsville, KY
Marcy State Hospital, Marcy, NY
Rusk State Hospital, Rusk, TX
In addition, refer to:

Table1. Differences Between Remotivation, Resocialization, and Reality Orientation.

Reality Orientation	Resocialization	Remotivation
1. Correct position or relation with the existing situation in a community. Maximum use of assets	1. Continuation of reality living situation in a community	1. Orientation to reality for community living
2. Called Reality Orientation and Classroom Reality Orientation Program	2. Called discussion group or resocialization to differentiate between a social function instead of a therapeutic need	2. Called remotivation
3. Structured	3. Unstructured	3. Definite structure
4. Refreshments and/or food may be served for identification	4. Refreshments served	4. Refreshments not served
5. Appreciation of the work of the world. Constantly reminded of who he is, where he is, why he is here and what is expected of him	5. Appreciation of the work of the world. Reliving happy experiences. Encourages participation in home activities relating to subject	5. Appreciation of the work of the world; stimulates the desire to return and function in society
6. Class range from 3-5, depending on degree/level of confusion or disorientation from any cause	6. Group range from 5-17, depending on mental and physical capabilities	6. Group size: 5-12 patients
7. Class meets one-half hour daily at same time in same place	7. Group meets three times weekly for one-half to 1 hour	7. Group meets once to twice weekly for one-half to 1 hour
8. Planned procedures-Reality Centered Objects	8. No planned topic; group centered feelings	8. Preselected and Reality-Centered Objects
9. Consistence of approach response of resident is responsibility of teacher	9. Clarification and interpretation is responsibility of leader	9. No exploration of feelings
10. Periodic RO test pertaining to residents' level of confusion or disorientation	10. Periodic progress notes pertaining to residents' enjoyment and improvements	10. Progress ratings
11. Emphasis placed on time, place, person orientation	11. Any topic freely discussed	11. Topic: Cannot discuss religion, politics, or death
12. Use portion of mind function still intact	12. Vast stockpile of memories and experiences	12. Untouched area of the mind
13. Greet resident by name, thank him for coming, and extend hand and/or physical contact according to attitude approach in group	13. Greet resident on coming, thank him, and extend handshake upon leaving	13. No physical contact permitted
14. Conducted by trained aides activity assistants	14. Conducted by RN, LPN/LVN, aides, and program assistants	14. Conducted by trained psychiatric aides

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Robinson, A. Remotivation techniques. American Psychiatric Assn. & Smith, Kline, & French Labs. Remotivation Project, no date.

Smith, Kline, & French Labs. **Remotivation Directory**, 5th ed. American Psychiatric Assn. Mental Hospital Service, no date.

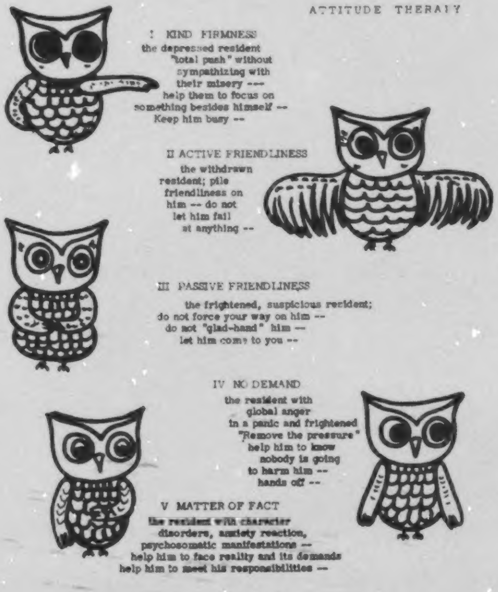
Attitude Therapy

Attitude Therapy is a form of behavior modification. It involves using certain prescribed attitudes in all dealings with elderly patients. The twin goals of Attitude Therapy are to reinforce desirable behavior and eliminate undesirable behavior.

There are five major attitudes to be used with five major identifiable behavior patterns (Fig. 3). A psychiatrist, psychiatric social worker, or other similarly trained professional should select the appropriate attitude to be used with the individual patient, but it is important that everyone coming into contact with the patient—including all staff members, volunteers, visitors, and other patients—participate in the therapy by using the designated attitude.

These behavior attitudes include:

(1) *Kind firmness.*—Kind firmness is prescribed for depressed elderly patients. Depressed patients have turned their hostilities inward. It is here where tasks should be structured to be menial, monotonous, and patient non-gratifying. When using kind firmness one must be careful to criticize the job or task but not the patient. It is important the patient knows that you know exactly what is to be done and that you expect your requests to be carried out to the letter. One should not sympathize with the patient's misery or attempt to sympathize with his feelings of worthlessness.



ATTITUDE THERAPY

I KIND FIRMNESS
the depressed resident
"total push" without
sympathizing with
their misery ---
help them to focus on
something besides himself --
Keep him busy --

II ACTIVE FRIENDLINESS
the withdrawn
resident; pile
friendliness on
him -- do not
let him fail
at anything --

III PASSIVE FRIENDLINESS
the frightened, suspicious resident;
do not force your way on him --
do not "glad-hand" him --
let him come to you --

IV NO DEMAND
the resident with
global anger
in a panic and frightened
"Remove the pressure"
help him to know
nobody is going
to harm him --
hands off --

V MATTER OF FACT
the resident with character
disorders, anxiety reaction,
psychosomatic manifestations --
help him to face reality and its demands
help him to meet his responsibilities --

Fig. 3. Attitude therapy.

(2) *Active friendliness.*—Active friendliness is used with withdrawn, apathetic old people, particularly those who have had few successes in relationships with people. The basic principle with active friendliness is to give the patient attention before he requests it. One should seek this patient out and spend extra time with him, give him sincere praise for accomplishments which show progress, and—insofar as possible—make certain the patient never fails. Active friendliness is the attitude most typically prescribed for patients in Reality Orientation.

(3) *Passive friendliness.*—Passive friendliness is prescribed for the old who are distrustful and frightened by active friendliness and closeness. It is important that the worker show his interest in and concern for the patient without pushing. One should wait for the patient to make the first move and then respond accordingly.

(4) *No demand.*—No demand is the attitude prescribed for aging/aged residents who are suspicious, frightened, or in an uncontrollable rage. Friendship and activities should be offered but one should not appear eager for him to participate. He should know the only thing you expect of him is that he not hurt himself or others.

(5) *Matter-of-fact.*—Matter-of-fact is the attitude prescribed for manipulative and seductive old people, as well as for those approaching normal behavior. Responses to the patient's pleas, complaints, and maneuvers should be consistent, casual, and calm.

Equipment

No particular equipment is needed for attitude therapy. It is helpful, however, to have some obvious means of identifying which attitude has been prescribed for individual patients. Green name cards on the door could be used for active friendliness, blue for passive friendliness, as illustrative techniques.

Personnel and Training

Every person who has contact with the patient should know and apply the prescribed attitude to be used with the individual patient. Five-day seminars teaching Attitude Therapy are offered through the VA Hospital, Tuscaloosa. Contact Mrs. Dorothy Scarbrough, Attitude Therapy Training Program, VA Hospital, Tuscaloosa 35401.

References

Folsom, J., Attitude therapy workshop. **American Archives of Rehabilitation Therapy,** June, 1966, 21-34.

Treatment Team, VA Hospital, Tuscaloosa. Attitude Therapy and the team approach. **Mental Hospitals,** Nov., 1965, 307-323.

Reinforcement Therapy

Therapy have become synonymous in the realms of therapy and rehabilitation in many leading institutions. Behaviorism is the objective of human and animal behavior in which reinforcement is one of various techniques for modifying interrelationships between response and action. Mental concepts such as emotion and sensation are replaced by concepts of stimulus, response, learning, habit, receptor, effector function.

The basic theory is that a person learns to behave in a way which allows him to experience a pleasant or rewarding stimulus. The general breakdown of the theory is as follows: (1) behavior is repeated if it is followed by a pleasant or rewarding experience or by a token reward; (2) behavior tends to disappear when no experience occurs, thus undesired acts should be ignored; the only time negative reward is used is when the behavior is so intent that there is a potential danger to self or others; (3) behavior is repeated or discontinued to whatever degree it is or is not rewarded.

It is of maximum importance to be careful in selecting the behavior to be altered. The selective behavior should be sufficiently broken down to be able to be generalized for aid in forming other desirable acts. The rewards should be given as soon after the desired act as possible. The *token* exchange is one starting point to be replaced eventually with a verbal reward, then to be phased out.

Tokens may be money, metal slugs that can be exchanged for privileges and/or items, candy, or any object items of value. The token reinforcement is especially beneficial when working in a home for the aged with regressed, disoriented residents. This is beneficial when working with groups of residents in a reality orientation class and when reinforcement is used as a motivator for memory retention, increasing attention span, and encouraging a response.

There can also be an immediate decrease in the frequency of bizarre or unusual behaviors and incidents of incontinance when positive behavior is reinforced by the use of tokens. Tokens can be used to increase interpersonal communication, taking of responsibility, decrease loss of early memories, and to increase eye contact and physical contact.

Programs can be maintained on the units in the home for the aged when the desired goal is to establish a more independent role for the resident. Areas that may be considered are: social behavior, self-care, unit work. Social behavior would include helping another resident, talking to another resident, starting an activity by oneself, and both the starting and the activity with others. Self-care might include bathing self, washing one's hair, dressing self, combing hair and brushing teeth, both with little help or without help, with the degree of self-help to determine the amount of reward, shaving self, and dressing especially neatly dressed in the morning. Unit work might include making one's bed, cleaning one's room, cleaning bathroom, dusting a dayroom, helping to distribute trays, washing ashtrays, or cleaning tables after meals.

A commitment on the part of the staff to this program can produce the desired results and develop and maintain the desire on the part of the resident to participate in this program to his fullest capabilities. From the first to the last day of therapy, good motivation is of prime importance. The staff, as therapist, must manipulate conditions to which behavior leads. Reinforcement may increase the likelihood that a desired response behavior may occur. It may be directed toward decreasing the likelihood that a response will occur because it is considered undesirable, maladaptive, or inappropriate. In this way, environmental interactions are synthesized in such a manner that therapist and resident are able to arrive at their mutually shared goals.

Equipment

There are many different objects/items useable for reinforcement. These should be chosen to meet the need of the individual and the group and limited only by the therapists' imagination. A detailed, but simple, bookkeeping system should be developed to keep track of all tokens.

Tokens should be earned on a set scale established by the particular Home.

Personnel and Training

Causes in behavior modification (Reinforcement Therapy) are offered by colleges and universities as well as in many special workshops and continuing education classes. In a Reinforcement Therapy program, the staff at all levels is trained in the mechanics of the project and is instructed that the program includes: (1) activities, social stimulation, and a more cheerful environment, (2) the residents are given more opportunities for self-direction, and (3) the staff becomes more aware of the benefit of the program to the patient.

References

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Freedman, A. M., & Kaplan, H. I. (Eds.), **Comprehensive textbook of psychiatry.** Baltimore: Williams & Wilkins Co., 1967.

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Skinner, B. F. **Verbal behavior.** New York: Appleton-Century-Crofts, 1957.

Individual Reinforcement Therapy

Individual Reinforcement Therapy studies are planned programs of therapeutic care which are designed to modify resident's behavior by specific therapeutic actions and an evaluation of results. The purpose of individual reinforcement therapy study is: (1) to modify the resident's behavior so that he may move toward a state of wellness and (2) to learn through systematic evaluation better methods of therapy. How this is undertaken is as follows:

Steps in the Process

(1) Choose a resident who has a particular need or one in whom you have a special interest.

(2) Obtain the resident's background, his age, former occupation, education, special talents or interests, illness record, length of hospitalization, and other data deemed pertinent.

(3) Review his pattern of behavior in the facility, especially reaction to assignments, general appearance, ability to express himself, general mood, contact with reality, and other viable documentation.

(4) Observe the resident's current behavior carefully for several days, and

  (a) describe in simple words the specific undesirable behavior you wish to modify such as, for example hitting, spitting, screaming,

  (b) obtain a baseline by recording the time and frequency of occurrence of the behavior and any factors that seem to precipitate or to increase or decrease it. Items to consider, among others, are amount of time, frequency, patterns,

  (c) list the desirable behaviors of the resident in terms of what is he doing right and what are appropriate behaviors, and

  (d) find out what is meaningful to this aged person that could be used conveniently and effectively as a reward or reinforcer for the behaviors to be encouraged.

(5) Set up one goal at a time and focus attention to adaptive behavior. One should pay as little attention as possible to maladaptive behavior.

(6) Identify the maladaptive behavior to be discouraged/extinguished and the desirable behavior to be encouraged/reinforced. A plan of action should be designed to bring about the desired results.

(7) Set up goals achievable in a reasonable length of time.

(8) Inform team members and others involved for consistency of approach.

(9) Set dates for team conferences to discuss program and plans at least once a week.

(10) Observe and record the residents' behavior and summarize on a specially designed study form. If feasible, a separate sheet on which to record the frequency of behavior should be developed.

(11) Continue until the goal has been reached, or change the approach if the desired results are not observed after a reasonable length of time

(12) Upon completion of the study, summarize the technique and include a summary of:

  (a) the resident's behavior at the beginning of the study and at the end, indicating what progress had been made in the particulars studied,

  (b) the specific treatment actions taken, and

  (c) your own evaluation of the study, particularly suggestions for improving the techniques employed.

Milieu Therapy

The Therapeutic Community (Milieu) concept is based upon the assumption that the social milieu itself can be the instrument of treatment. The realization that people change, learn, and mature as a result of their interpersonal and social relationships and experiences is not new. It is interwoven within all theories of personality development.

Harry Stack Sullivan and the Menningers were among the first to use the concept of the Therapeutic Community. The Menningers set about to create a favorable array of interpersonal relationships for each patient by prescribing attitudes for staff adoption.

The Therapeutic Community is a very special kind of milieu therapy in which the total social structure of the treatment unit is involved as part of the helping process. It is organized and developed in order to make available for treatment purposes all relationships and activities in the life style of the patient. It differs from other kinds of therapy to the extent that it operates on the principle that all of the social interpersonal processes within the institutional environment are important and relevant to the treatment of the individual. No elements are left out of the treatment, and all transactions are considered potentially therapeutic.

Historically, the Therapeutic Community bears certain resemblances to other treatment modalities. For instance, it has much in common with the moral treatment of the early and middle 19th century. The respect for human rights, the family feeling of hospitals, the humane consideration for patients, and the recognition of the therapeutic effects of activities are all elements shared by moral treatment and the Therapeutic Community. However, while its roots have many connections, it seems clear that the Therapeutic Community represents a departure from previous treatment methods.

All facets of the life of the older resident/patient in the social milieu are seen as presenting opportunities for living-learning experience. The role of the staff is to use their various skills to realize these opportunities to the fullest. The environment then becomes one in which there is a favorable climate for helping the older resident/patient to gain an awareness of his feelings, thoughts, impulses, and behaviors. The aim is to help him to try new skills in a relatively safe environment, to help him achieve a realistic appraisal of his social and interpersonal relationships, and to help him to increase his self-esteem.

In such a treatment setting, a value is placed upon a greater sharing of responsibility with patients than is found in the usual hospital. The rationale is that by offering a great degree of meaningful participation in the decision-making functions of the community, trust and respect between patients and staff are developed.

Emphasis on patient responsibility has another value. The treatment process addresses itself to the intact ego function of each patient. It assumes that even the sickest person is not wholly sick, but that only part of his ego functioning is disturbed. Each person starts with what he has and builds from there. In the usual course of events one is not permitted to say, "I cannot participate in anything because I am too sick."

Most Therapeutic Communities discourage regression by patients. Ordinarily patients are not permitted to go to bed (stay in bed) during the day or to withdraw from all social contacts. Instead, there is an expectation by the community to participate, to assume responsibility, and to interact.

A Therapeutic Community may be the treatment method in a 24-hour hospital, a day hospital, a rehabilitation center, a halfway house, and most particular, in a nursing home or a home for the aged. There have been, as yet, insufficient experiences to say what kinds of people are most or least likely to benefit from this kind of treatment, or in what kinds of settings this method may be effective.

Experience is, as yet, insufficient to determine the best type of training to prepare people for employment in these settings.

Problems of a Therapeutic Community

There are at least seven major problems related to the Therapeutic Community:

(1) There is no clear, conceptual model underlying the Therapeutic Community. The problem lies in the fact that while there is both intrapsychic and social models, a super-ordinate model is required.

(2) While the gains, in terms of personal and professional satisfaction for the staff are sizeable, the lack of clear boundaries among the various professional identities is anxiety-provoking.

(3) Group responsibility, unless skillfully nurtured, can become distorted in practice to become no one's responsibility.

(4) There is a continuing possibility that the individual patient may become lost in the concern for the group. It seems clear that in a well-functioning community there is an increased concern and respect for the individual. When patients are permitted to withdraw, to become isolated, this in itself is a problem which must be dealt with by the community.

(5) The Therapeutic Community may teach values that are appropriate to its own culture but that might lead to difficulties if the learner were to apply these elsewhere. For instance, while a patient may be encouraged to speak his mind in the Home, it may be more appropriate to hold his tongue when speaking to someone outside the Home (family, friends).

(6) Research and program evaluation are complex because of the proliferation of the factors leading to change.

(7) Since few centers in this country currently offer training especially suited to functioning in a therapeutic community, it remains the function of the setting itself to train its own staff.

Equipment

Milieu therapy requires no special equipment. However, the physical structure must invariably be modified to meet the needs of the group. The furnishings should reflect the needs and aspirations of the community. It should be livable and comfortable. Brightly colored bedspreads and draperies give the rooms brightness and individuality. Pictures on the walls add much to the rooms and the Home in general.

Personnel and Training

Because milieu therapy is an all-inclusive way of treating the individual patient, it requires the cooperation and support of the entire staff. All staff members should be made aware of their role in the rehabilitation process. For members of the treatment team, work in a Therapeutic Community requires a reexamination of the roles for which they have been trained. Previous training frequently has not prepared them for the jobs in which they find themselves. Fortunately, the Therapeutic Community lends itself especially well to a continuing process of in-service training.

Staff training programs in Milieu Therapy are now available through the Institute of Gerontology, University of Michigan-Wayne State University. For further information contact Ypsilanti State Hospital, 3501 Willis Rd., Box A, Ypsilanti, MI 45197.

References

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PREVLAB

The PREVLAB program (Prevention of Loneliness, Anxiety, and Boredom) asks the question,

> Is the sensory input of older people in nursing homes and homes for aged adequate to prevent or alleviate problems of loneliness, anxiety, boredom and frustration, or are there important benefits which would accrue by examining the problems and by making constructive changes?

PREVLAB is based on the concept that sensory input can be altered in a positive direction for most subacute or chronically ill patients by introducing high-interest items into their immediate environment and by altering or modifying the design and decor of the facility itself. These changes also help to improve the quantity and quality of conversations that patients have with other patients, visitors, volunteers, or with Home staff.

Multi-high interest items can be introduced by development of multi-item kits or by designing or modifying Homes so that display cases are available for exhibits and demonstrations. By providing multi-item kits, patients may have the possibility of self-stimulation and have available a variety of useful diversional activities. It is difficult to know what past interest patients have had or predict what will prove of interest to them while in the nursing home. For this reason a variety of interest items should be made available to increase the probability of stimulating and diverting interest in a positive way.

The basic plan for a PREVLAB program in a Home requires that multi-item kits be developed, distributed, and periodically serviced; that resources capable of making cultural and diversional contributions to the nursing home be identified and mobilized; and that personnel develop and survey nursing home to determine the needs of the patients.

The multi-item kit program is developed by following certain steps: (1) Planning Phase, (2) Collection Phase, (3) Assemblage Phase, (4) Distribution Phase, (5) Utilization Phase, (6) Evaluation-follow-up Phase. Attention is called to the reference for more special detail on how to develop a multi-item kit and how to undertake each of the six phases.

Equipment

It is possible to make up interesting multi-item kits from inexpensive items or surplus items found in homes or in most communities. Items should be chosen on the basis of having: appeal to vision, tactile, or odor senses; humorous or gimicky aspect, cultural or historical interest; active involvement (handling) by the patient; a potential long-range patient interest time; and being relatively inexpensive, compact, light, and not perishable.

Personnel and Training

Anyone can be responsible for a PREVLAB program. For training materials and design for the kit contact F. R. Mark, MD, 18-34 Parklawn Bldg., 5600 Fisher's Lane, Rockville, MD 20852, for the publication, "A Project for Nursing Homes or Hospitals." It has been suggested that volunteers could be utilized to put together new kits or refurbishing older kits.

References

Mark, F. R. A project for nursing homes to combat loneliness, anxiety, and boredom. **Nursing Homes,** 1973, **22,** 32-33.

Sensory Retraining

Sensory Retraining (also known as Sensory Training) is a technique that is used effectively with the regressed older person who shows an inability to interact with his environment. The goal of Sensory Retraining is to bring this type individual back into touch literally with his surroundings.

Sensory Retraining is a structured group-individual experience involving all five senses. The aim is to provide the older person with differentiated stimuli to improve his perception of, and response to, both the physical and human environments.

Members of a Sensory Retraining group sit in a circle. The leader introduces himself to the group and the participants to each other. He then explains the purpose of the meeting, e.g., to exercise the senses through which the world is known. Following the introduction, the leader discusses each sense separately and provides some type of activity, using a particular sense. At the end of the session the leader thanks the participants for their cooperation and reminds them when the next meeting will be held.

Because Sensory Retraining is an elementary technique, it is important the therapist recognize he is working with adults and should conduct the session on an appropriately adult level.

Equipment

There is an infinite variety of objects useful in stimulating the senses; mirrors and colorful objects stimulate use of the eyes; sharp or acrid-smelling substances contrasted with sweet, pleasant-smelling things exercise the sense of smell; records, whistles, tambourines, clapping, singing, humming, and whispering provide a variety of sounds; candy, pickles, potato chips, show different types of tastes; soft, hard, smooth, rough, hot, and cold items offer tactile stimulation. To avoid monotony, it is important to vary the materials used and to contrast as much as possible day-to-day activities.

Personnel and Training

Any staff member may serve as a sensory-retraining therapist. Patience is an important requirement.

For information on staff training for sensory retraining, contact Leona Richmand, OTR, Bronx State Hospital, Bronx, NY.

References

Huber, R. Sensory training for a fuller life. **Nursing Homes,** July, 1973, **22,** 14-15.

Richman, L. Sensory training for geriatric patients. **American Journal of Occupational Therapy,** 1969, **22,** 254-257.

Self-Image Therapy

The conceptual theory of Self-Image Therapy is based on the work of Maxwell Maltz. The self-concept contains all the descriptions of the objective "me." This includes not only the portraits rendered by the individual but also his impressions of his portraits done by himself or someone else. Once an idea or belief about himself goes into this picture it becomes true as far as he personally is concerned and is added to the mental blueprint each person carries of himself.

The use of group reading with physically disabled geriatric patients is a successful way of organizing and maintaining a cohesive group. The development of a group seems to provide the patients with a greater sense of security and belongingness. The use of group reading as a tool helps the handicapped, institutionalized geriatric patient reach his maximum level of adjustment and enhances his self-image. This technique can be used with a variety of disabilities and has been of benefit when working with residents with Parkinson's Disease, multiple sclerosis, rheumatoid arthritis, and with others who have had amputations or have been severely burned.

Self-Image Therapy is based upon the rationale that as a person grows older he experiences feelings and reactions in terms of self and their impact upon self. He becomes what he thinks he is. If the environmental factors distort reality, then a poor self-image may be formed. This awareness of his environment, plus age and physical condition of the individual, are factors which determine the particular kind of relearning involved. His view of his environment and of his place in this environment determines his reactions and his behavior. Social interaction within this environment is of importance, for without adequate interpersonal relationships a concept of self cannot be maintained. Man defines and perceives himself as he believes others perceive and define him; thus, giving him a reflected or "looking-glass self."

An older person who has a physical disability may have a distorted concept of self. He is not like other people; he cannot do certain things others can; he has often been laughed at, chilled, or ignored because of his disability. This may cause an individual to feel that he is not as good as a normal person and that he is just a freak. This attitude about self leads to failure and unhappiness. The nightmare of failure tends to be compensated through the creation of a rigid and/or idealized self-image, that is, a much distorted image of the self. The staff needs to work closely to help the patient maintain and/or change his concept to a more realistic one.

The purpose of Self-Image Therapy, utilizing reading groups as its tool, gives the therapist the opportunity to help the patient/resident clarify his identity, to increase his self-esteem and his acceptance of self and others, to assist in developing group cohesiveness and a feeling of belonging; to assist in adjusting to the disability by providing an opportunity to explore and discuss similarities and differences in abilities and limitations, to explore feelings and attitudes concerning disabilities, to provide an opportunity to share experiences and frustrations resulting from disability; to realistically assess strengths and assist the person in becoming aware of his assets, and to establish an environment in which the person is genuinely respected.

Only by helping a person gain a sense of respect for self and a willingness to accept the self for what he is will he be able to live a fuller, happier, more successful life.

Equipment

The book to be read is the choice of the group; however, suggestions are made by the leader. Film strips, pictures, posters, and/or items pertaining to the book may be used to supplement the readings.

Personnel and Training

Any staff member may serve as a leader in a Self Image Therapy group. An observer in the group is also necessary to report pertinent observations about problems and difficulties of group operation and reactions, both verbal and non-verbal, of each group member. The leader may have more experience with groups, but the observer should have skills in working with people. The leader and observer work together on behalf of the group, one helping to guide the group, and the other watching how it works.

For further information on Self-Image Therapy and training, using the reading group technique, contact Occupational Therapy Dept., Dallas Home for Jewish Aged, 2525 Centerville Rd., Dallas 75228.

References

Johnston, M. Group reading as a treatment tool with geriatrics, **American Journal Occupational Therapy,** 1965, **19,** 4.

Maltz, M. **Psycho cybernetics.** New York: Essandess Special Editions, 1960.

Burnside, I. Group work among the aged. **Nursing Outlook,** 1969, **17,** (6), 68-71.

Reality Therapy

Reality Therapy is a technique developed by William Glasser which attempts to lead emotionally disturbed patients of all ages away from denying the world and helps them to recognize that reality not only exists, but that they must fulfill their needs within its framework. The fundamental principle of Reality Therapy is that all human beings satisfy their basic needs through involvements with other people.

Glasser feels that there are two basic psychological needs: the need to love and be loved, and the need to feel worthwhile both to oneself and to others. Reality Therapy is particularly important for the institutionalized older person who feels worthless and rejected. Reality Therapy teaches patients better ways to fulfill their needs. Interpersonal relationships will not be maintained unless the patient develops more satisfactory patterns of behavior.

Reality Therapy consists of five separate but interwoven procedures. The first step is involvement. The primary therapist, as well as all concerned team members, must pierce the patient's wall of loneliness and self-involvement and convince him of his sincere interest in him as a human being. The second step is "current behavior." In this step the patient becomes consciously aware of his behavior at the present time. The third step is evaluation of behavior. The patient must look critically at his behavior and judge it on the basis of whether it is responsible and beneficial to himself and others. The decision to change or alter behavior is a rational decision made by the patient himself, not the therapist. In the fourth step the patient and the therapist formulate a realistic plan to follow in changing the patient's behavior. The plan should be sufficiently ambitious to produce noticeable, recognizable change, but not so grand that failure is likely. A failing person, after all, needs success. He needs small steps to attain it. The fifth step is the implementation of the plan. The therapist helps the patient gain the experience of fulfilling a commitment to a responsible plan. The patient is held responsible for his behavior, something is expected of him, and somebody cares about him. If one plan does not succeed, another should be developed and tried until one works.

Equipment

Reality Therapy requires no special equipment.

Personnel and Training

Courses in Reality Therapy are taught in colleges and universities and are often offered as one-day institutes and special workshops. Reality Therapy should be conducted only under the direction of a psychiatrist, psychologist, psychiatric social worker, or some other professional specifically trained in the theories and techniques of Reality Therapy.

Reference

Glasser, W. **Reality therapy.** New York: Harper & Row, 1965.

Summary

Appropriate care of the aged requires the acceptance and implementation of a treatment model which is essentially built on the determination that sick older people can improve function. The modalities presented are based upon the following assumptions:

(1) If the normal patterns of living could be restored, senility could be reversed.
(2) Senile symptoms, or at least some senile symptoms, could be substituted for frustrated impulses due to inner conflict, or a protest against inner conflict.
(3) Memory losses may be selective.
(4) Disorientation and confusion could be reversed by relearning the skill of thinking and remembering.
(5) Mental ability that has deteriorated through disuse could be restored.
(6) Stimulation of all kinds (sensory, emotional, occupational) could be curative for the disorientated and confused person.

If a treatment model modality is selected and used, it is believed that such intervention can break the cycle of senility which is described in the Spiral of Senility Chart (Fig. 1). The result is a richer and rewarding life for the elderly, their families, and their caretakers.

Bibliography on Treatment Models and Their Relationship to Measures of Program Effectiveness.

Becker, W. C. **Parents are teachers.** Champaign, Ill: Research Press, 1971.

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Diebert, A. M., & Harmon, A. J. **New tools for changing behavior.** Champaign, Ill: Research Press, 1970.

Glasser, W. **Reality therapy, a new approach to psychiatry.** New York: Harper & Row, 1965.

Harris, T. A. **I'm OK—You're OK, a practical guide to transactional analysis.** New York: Harper & Row, 1967.

Holland, J. C. Ethical considerations in behavior modification. In **Current Ethical Issues in Mental Health.** Washington: NIMH, HEW Publ. No. HSM 73-9029, 1973.

Kiresuck, T., & Sherman, R. E. Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. **Community Mental Health Journal,** 1968, 4 (6).

Programmed Instruction in Goal Attainment Scaling. Minneapolis (50 Park Ave. S.): Program Evaluating Project, 1971.

Individual/Class Activities

The activities in this section of the module supplement those already presented in the content section. The sample activities in this section have been divided into two parts, one for instructors to use with students and one for counselors to use with older adults. Many activities could be used with both students and older clients.

ACTIVITIES FOR USE WITH STUDENTS

Activity: My Own Retirement
Time: 25 minutes
Purpose: To help the student explore his/her feelings about retirement and develop empathy for those clients who are retiring.

Procedure: Give students a sheet of paper. Have them fold it lengthwise into four parts and write one of the following questions at the top of each column: "What would I consider to be most ideal?" "What would I want most?" "What would I dislike most?" "What is my most realistic view?" After they have written their responses to each of the above questions, ask the students to form groups of 5-7 persons and to discuss their feelings about retiring.

Activity: Experiencing Reminiscence
Time: 50 minutes
Purpose: To allow students to experience the technique of reminiscence.
Procedure: Experiencing reminiscence personally demonstrates its effectiveness for use with the aging. Students select a partner and locate a place in the room where they are able to speak with one another privately. One student begins the exercise by taking a few moments to reflect on his/her life and then taking the next 15 minutes to recount some memories, good and bad, to the partner. At the end of 15 minutes roles are reversed. Each student should listen attentively as the other speaks, interrupting or responding only to clarify, to express interest and understanding, or to facilitate the reminiscing experience in other ways.

In follow-up processing, ask students what the reminiscence experience meant to them and how they could use it with a group of older persons. Reminiscence is sometimes used with the depressed elderly. It may be a stimulating and satisfying activity for older adults in support and personal growth groups.

Activity: All We Ever Wanted to Know About Sex After 60
Time: 30 minutes
Purpose: To allow students to ask questions anonymously about sexuality in older adulthood
Procedure: Arrange the class in small groups of 5-7 members and give each student two 3 x 5 inch index cards. Ask students to write two questions and two facts about sex after sixty, one per card. Then have a discussion leader in each group gather and mix first the cards with questions and then the cards with facts. The leader reads each question for the group to discuss, drawing from the fact cards when they apply to the discussion. The remaining fact cards can be read after the questions are discussed, time permitting.

Finally, have the class form a large circle to discuss the questions that were not clear in the small groups and to share particularly interesting facts. The instructor should correct any important errors of fact and point out sources for further study.

Activity: Sharing Our Grief
Time: 45 minutes
Purpose: To ease left over grieving for a deceased loved one (or to help students who have not experienced the death of a loved one to develop more sensitivity).
Procedure: Students should be seated in a large circle, with the lighting in the room preferably subdued. Have group members hold hands and in turn verbally compose a letter to someone they loved who is now dead. Another option is for the group members to compose a letter to be read by a loved one soon after their death. This exercise often touches on unfinished business that students previously repressed. Deep emotions often surface, accompanied by tears, which stimulates the grieving process. This exercise should be followed by processing, emphasizing the importance of the grieving process.

Activity: Give Us A Cheerful Face
Time: 25 minutes
Purpose: To demonstrate to students the negative effect that inappropriate responses can have on grieving persons.
Procedure: Choose a student to role play a recently widowed woman. The instructor role plays the part of the helper, saying,

> "Hello, Bea, I know it is hard, but you will soon get over it. Just keep a good stiff upper lip.... What about a smiling face? Try it...You're too upset? You poor thing. Don't worry. I'll help you... in the first place let's get you moved out of this house within the next month or so, too many memories here. And keep Joe's sister away. She'll talk your head off. Joe would have wanted it this way, you've got to pull yourself together for Danny's sake."

The instructor should embellish these statements at will, and the class should become highly critical of the instructor's approach to the widow's grief needs. At the close of the role play, challenge the group to better assist the widow with her grief in their own fashion.

Activity: Vignettes
Time: Variable
Purpose: To provide students with the opportunity to demonstrate and improve competencies learned in courses on counseling older adults.
Procedure: Assign the following roles.

Situation 1:

Mr. Barton: You are an 83 year old semi-retired business man who 55 years ago started a store. Largely through your vision and ability the store has grown to be the most prosperous department store in the county. When you retired at 73 it was agreed that an office and secretarial services as needed would be made available to you. At first you came in almost every day and continued to work. But lately you only appear about two half days a week, accomplish a few personal things and then enjoy talking to the boys about "the good old days."

Mr. Lawton: You are an executive on the board for Mr. Barton's store. You are personally very fond of the man for it was he who gave you your start. It has been reported to you numerous times that Mr. Barton has become a "pest" around the office and that he interferes with work. Employees and other executives are beginning to really put the pressure on to see that Mr. Barton's distracting visits cease. You recognize that the office is a very big part of his life. You are concerned for his welfare, you have agreed to talk with him rather than leave this task to a less caring colleague.

Situation 2:

Bessie Smith: You are a 78-year-old widow who has been living with your son and daughter-in-law. A few weeks ago you suffered a mild stroke and you now have some difficulty walking. While staying at a small convalescent center you are beginning to improve physically and will probably be discharged from the facility shortly. When looking to the future you are distressed with the increasing physical and social losses you have to adjust to. You are very depressed and it has been recommended that you seek the assistance of a counselor.

Counselor: You are a counselor working for an outreach counseling service associated with a Senior Citizen Center that gives you easy access to the varied community resources. Mrs. Smith has been referred to you from the convalescent center. Your goal is to make her years ahead as self-fulfilling as possible. What assistance will you give Mrs. Smith?

Situation 3:

Mr. Larry: You are a 71-year-old man who lives alone with your wife in the same community where you have lived for 43 years. Two of your adult children and multiple grandchildren also live in this community. You have been retired for six years and have enjoyed your retirement substantially because you receive an adequate pension check and have enjoyed relatively good health. However, the bottom seems to have dropped out of things because two days ago you learned that you have cancer of the liver.

Counselor: You are a counselor in a community mental health center. There is a Mr. Larry waiting outside your office to see you. As you open the door, you notice that he appears very depressed and anxious. This is the first time he has visited the Center and you don't know what he wishes to talk about.

Situation 4:

Mrs. Casey: You are an 83-year-old widow who has failing eyesight and hearing but otherwise relatively good health. You live alone in a complex for older adults very close to your adult children, grandchildren, and great grandchildren. You learned this week that one of your great-grandchildren, Tommy, who is seven, is dying of leukemia.

Counselor: You are a woman working in an adult day care program as a counselor. You are quite familiar with the topic of death from numerous discussions with your clients. You are aware of some older persons' need to talk about the inevitability of death. One day Mrs. Casey comes to your office weeping and finally cries out, "My grandson is dying of leukemia, he's such a terrific little boy. Why couldn't it have been me?"

Situation 5:

Daughter: You are a 49-year-old woman who has always been close to your mother, particularly since the death of your father eight years ago. Over the last couple of years your mother has suffered some considerable declines and requires a great deal of assistance in her home. Through the week she has a homemaker service come in, but for the last 11 months almost every weekend you have made the 105-mile trip between her home and yours to care for her. Sometimes your family makes the trip with you, but at the end of a hard work week you hate to impose on your husband and feel like your children have lives of their own. The constant trips are beginning to wear at your married life and the visits haven't been that rewarding because your mother constantly nags about not having the rest of the family present.

Counselor: You are a counselor in a community mental health center. You have an appointment with a woman from another state who is seeking help for her mother, an elderly, city resident.

Activity: Field Experiences

Time: To be determined by instructor

Purpose: To allow students to examine their own feelings about and their suitability for working with older people.

Procedure: For this exercise, students may be placed in nursing homes, nutrition centers, senior citizen centers, etc. They should interact with older persons, develop relationships, observe the activities of that site, etc. Ask them to keep a log and note their personal reactions to their experiences. Some students will be enthusiastic and see vast new possibilities; others will be "turned off" and question their suitability for working in the area of aging. If this experience is scheduled early in the students' academic career, they can empirically evaluate their decision to specialize in counseling older adults.

Activity: Preparation for Interviewing the Elderly

Time: 25 minutes

Purpose: To help students strengthen interviewing skills that will enhance communicating with the older adult.

Procedure: Have students form small groups of 5-7 persons. Ask each student to help the others prepare to interview two older persons in a field experience. No other directions are given. After ten minutes have spokespersons from each group share their suggestions with the larger group.

Some key points for consideration include: (1) Determine what the goals of the interviews will be. Students may compare the person's life-style or attitudes of today with those of the past or obtain their views on retirement or today's youth or their feelings about growing old in today's society. (2) Open-ended questions rather than those encouraging short replies are desirable. Examples of open-ended questions are: "What were the high points in your life?" "What do you feel about your life today?" "What were the best things?" "What were the worst things?" (3) Be friendly, but avoid talking about yourself during the actual interview. Permit full expression of thoughts from the older person. (4) Avoid being judgmental or offering personal viewpoints. Do not prejudice the results of the interview.

Activity: Interviewing Two Older Persons

Time: Variable

Purpose: To facilitate a deeper understanding of the life styles and coping skills of different elderly persons.

Procedure: Using sites identified earlier (under field experience) or another environment where older persons are numerous, students conduct two interviews with two different older persons. The following approaches may reveal some interesting diversity in the attitudes and perceptions of older persons interviewed.

Interview two persons with a few similar characteristics (i.e., two middle class, white widows) in two distinctly different environments (i.e., nursing home and an adult day care center). Compare and contrast the two individuals and their attitudes about old age.

Interview an ambulatory older person and a nonambulatory older person. What influence does mobility have on the personal happiness of these individuals in old age?

Interview two people within the same environment — one who appears happy and one who appears unhappy for whatever reason. Does their involvement in the environment have anything to do with their personal outlook on life in old age?

Perhaps the greatest benefits of this field experience are the mutual satisfaction and excellent rapport usually established between the older person interviewed and the interviewer. Students often find that they relate easily to older persons, who in turn enjoy their interviews with the students.

Career Planning Activities

Activity: New Careers for Old
Time: 45 minutes
Purpose: To help older clients learn more about the job market and about themselves through a search of newspaper employment advertisements.

Procedure: Ask group members to study employment ads in all newspapers serving the geographical area they would consider for employment and clip out every ad that seems interesting and personally appealing. Rather than censor on the basis of job qualifications or other practical matters, they should simply collect ads based on personal preference, i.e., "as if you could do anything you wanted to." Have group members bring their ads to the next session, and through group sharing, provide extensive job opportunity information to everybody. Members can also engage in values clarification experiences, analyzing choices to reveal patterns and identifying broad fields of interest. Follow up sessions can explore the practical components of job selection and gradually help the clients focus on specific career goals and aspirations.

Activity: Recognizing Our Competencies and Building on Them
Time: 60 minutes
Purpose: To encourage older persons to explore past accomplishments and satisfactions as a guide for making a career change, undertaking new experiences in volunteer work, or otherwise using their skills effectively.

Procedure: Have the group divide into triads, preferably with others they don't know very well. In the triads, participants should each recall an experience in their lives they consider successful. The accomplishment doesn't need to have been outstanding. It is only important that the participants themselves be proud of the achievement. For example, one woman recalled learning to ice skate in her thirties. She went to a rink one day, watched others skate, and within two hours performed quite ably. As she thought of this experience, she learned about her abilities and strengths. She found this insight helped her consider the possibilities involved with career change.

The groups should next take several minutes to write about a personally successful experience. Have them look at the completed written experience and list the abilities and strengths reflected in the experience. Modesty aside, participants should then take turns sharing their experiences and listing the strengths and abilities shown in their experiences. Other members of the triad can make supportive comments and point out additional abilities and strengths overlooked by the individual. The groups finally spend time sharing ideas regarding careers or volunteer work where the skills and strengths of each participant might be used.

Besides using a past success to identify abilities related to a new career or volunteer work, this exercise involves aged persons in the process of career counseling and enhances the ego by recognizing excellence the person may not have seen in him/herself previously.

Activity: Assessing Educational Needs and Preferences
Time: 50 minutes
Purpose: To provide a positive climate where persons with diverse educational backgrounds can personally assess themselves and begin setting goals.

Procedure: Ask group members to review their educational history and make a list of all their educational experiences: public school, vocational training, military training, higher education, on-the-job training, adult education, etc. Then ask them to list their informal learning experiences: hobbies, special parenting skills, household management, budgeting, traveling, shopping, etc. Each person should identify first what was most positive and then what was most negative about each experience. A simple chart can be used to organize the information in columns.

The whole group then discusses past experiences, focusing on values and attitudes that have shaped each person's approach to education. Ask group members to review their lists and identify five things (ideas, skills, etc.) they would like to learn more about.

Activity: Learning About Learning
Time: 50 minutes
Purpose: To help older clients gather information about education in their community and to foster collaboration among group members to achieve a common task.

Procedure: Ask group members where they can go in the community to continue their education or retrain for a new job. Members should share what they know and then speculate on other possibilities within their community. Next move the group into a brainstorming session on the question, "Where could you get information about education and/or training programs?" After brainstorming, the group should select the possible and practical sources from the list. Each person takes responsibility for checking on several sources and preparing to report to the group at the next session.

Activity: Brainstorming Housing Options
Time: 50 minutes
Purpose: To encourage older adults to explore the options for residential living by means of brainstorming.
Procedure: Have participants come prepared to discuss in depth at least one housing option, its disadvantages, and its advantages. Options should include innovative housing choices and substandard or degrading accommodations.

Ask the participants to form small groups and "brainstorm" for ten minutes, listing as many housing options as are possible without discussion or evaluation. To help the creative flow of ideas, wild ideas should be accepted and negative judgments avoided. After ten minutes, a representative of the group with the most options reads off the group's list. Spokespersons for other groups can then add options not previously mentioned. Finally, the small groups discuss the options that seem particularly worthy of consideration and participants share their prepared information regarding the housing options.

Activity: Residential Living Has Its Problems
Time: 60 minutes
Purpose: To provide role playing on the problems of communal living so that older clients express their feelings and concerns and consider how to handle difficult or uncomfortable situations using assertive communicating and problem-solving skills.
Procedure: Selected members of the group are given the following roles:

Situation 1: "The Itch"

Mrs. Lowe: You are a kind-hearted person who is concerned for other people and wishes to be helpful. However, you have been plagued constantly by Mrs. Pratt, the person across the hall, who frequently knocks on your door, engages in interminable and boring chatter, asks to borrow food and clothing, and requests special favors. You are in the middle of eating breakfast and there is the familiar knock and the all too cheery greeting. You slowly open the door and the unwanted visitor pushes her way in.

Mrs. Pratt: You have become so forgetful. You don't have any milk left for your coffee. Fortunately the woman across the hall (what is her name?) is particularly nice. She will be willing to give you some milk and some packages of sugar substitute, too. This will give you the opportunity to tell her what to do in case those heart pains come back and you need immediate attention. A little conversation will break up the loneliness. Your neighbor is opening the door and in your most cheerful voice you call, "Good morning, good morning," as you quickly enter her room.

Situation 2: "Making Friends Isn't Easy"

Mrs. Hochberg: You are sitting at a desk in your living room and have just finished writing a letter to a friend in another city. You have expressed how much you miss her and how difficult it has been for you to meet new people. You are so lonely. You want a new friend. You read the letter aloud before sealing it into the envelope.

After each situation, ask for reactions and comments from the group members.

Activity: Life Together: For Better, For Worse
Time: 60 minutes
Purpose: To focus on the positive aspects of a couple relationship (past, present, and projected future) while also recognizing existing and potential causes of dissension.
Procedure: Divide the group into small groups and lead them in the following fantasy. (Single persons not involved in a long-term couple relationship may focus on any meaningful personal relationship, identifying with a close friend or relative.)

Instructions:

"Think back to the beginning of a meaningful relationship. Picture your spouse or another significant person. How did s/he look? What was s/he wearing? Recall what you talked about in those days — your concerns, your interests, anything. Concentrate on a conversation you might have had. What did you say or what might you have said? How did the other person respond? Try to recall the words, the tone of the voice, the facial expressions, the touch of his/her hands. What feelings were taking place within you at the time about yourself and about him/her? Go on further with the conversation as it was or might have been. Get in touch with the feelings you had then.

"Now picture yourself in your middle years, the way you are or were or expect to be. Look at yourself. What do you look like? Look at the other person. What does s/he look like? Think of talks you have had or are having or might have in the middle years regarding your concerns, your interests, or anything. Focus on a particular conversation. What is each of you saying? How are you saying it? Listen to the sound of your voices. How does the other person look to you? Do his/her features or body movements communicate any messages to you? What are your feelings about him/her and about yourself at this time? Observe carefully. Examine your feelings.

"You are now beyond the middle years. You are older. See yourself now. Visualize the other person as s/he looks now or as you expect him/her to look at this age. You are holding a conversation. What are you saying to each other? How are you saying it and what are your feelings? Make this experience real. Give yourself time. (Long pause)

"Think now once more of each of these three periods — the early years of your marriage or other relationship, the middle years, and finally the later years. How were you communicating? How were you relating? How were you feeling about yourself and the other person? What particular interests and concerns did you have at each stage? What were the similarities and/or differences in these stages?"

Invite the small groups to share reactions. After twenty minutes, stop the discussion. (It may be resumed later with the entire class.)

Continue the exercise with further instructions:

"Concentrate now on couple relationships in the later years. What positive aspects can you anticipate? What are most likely to be problems? Consider these questions for awhile. (Pause)

"Now that you have considered the positive aspects and possible problems of couples in the later years, make suggestions for overcoming problems and enriching relationships at this stage of life."

A general sharing of ideas should follow the small group discussions. Direct the participants to examine the needs, concerns, and interests of couples at various stages of their relationship. What are the level and quality of personal communication? Are there any discrepancies between the spoken word and nonverbal behavior in the relationship? While not a substitute for therapy and not designed to save a failing relationship, this exercise can increase awareness of and sensitivity to the feelings and behavior of oneself and one's partner. Planning and looking ahead to shared interests and a deepening attachment can displace the boredom, frustration, and bitterness that too often mar the relationships of older couples.

Sample Assertive Training Group Activities for Older Persons

Activity: Behavioral Rehearsal: Fantasizing a Trial Run of New Responses

Time: 45 minutes

Purpose: To help older persons learn their rights, which are often disregarded by those with whom they frequently associate, and to acquaint them with methods of asserting themselves effectively.

Procedure: Introduce group members to the use of imagery and fantasy techniques by asking them to focus on some event or interaction they experienced within the past two days. Ask them to close their eyes and begin to relive the situation step by step and moment by moment as it evolved. Guide the group through their recollection using verbal cues and key phrases such as:

"Focus your thoughts on one experience of the last two days that you wish to recall and re-experience. First get in touch with where this occurred. Was it in your home? Out on the street? In a public building? In a car? Bus? Remember what time of day or night this took place. What were you doing immediately before it happened? Identify the others who were around. Was anyone else involved? Can you remember your feelings during the incident? After?"

Other cue questions or statements can be added to help group members get into the fantasy activity. After sufficient time (approx. 10 minutes) has elapsed, ask the group to return to the present by slowly moving from their fantasy location to the time and place where the group is now meeting and when they feel ready, to open their eyes.

Then ask group members to share their fantasies and any feelings they care to discuss about the fantasy and/or about the process of using imagery.

When participants are comfortable with this technique, it can be used effectively for behavioral rehearsals.

Group members are presented with a situation that requires assertive behavior. They are asked to fantasize the event so that it is clearly detailed, then imagine their personal response, using of course their new assertion skills. Members then share their fantasies, their projected responses, and in doing so can explore and relieve anxieties or fears often associated with the situations described. Examples for fantasy rehearsals:

1. You have been standing in line at the bank for at least 20 minutes. You realize this was a bad time to come to the bank, Friday lunch time before a long holiday weekend, but it was the only time you could get a ride here and you must deposit your Social Security check before the weekend. Now you are getting impatient because you are keeping your neighbor (who graciously volunteered to drive you here) waiting. Just as you move up to the window to be served, the teller walks away and seems to be taking care of some business on the far side of the bank office. You see an official looking person managing the customer traffic. You decide to act. You say....

2. You have been looking forward to a quiet dinner with your spouse. The past few weeks have been hectic with visits from the children, grandchildren, preparing for the holidays, business matters that needed tending, etc. It seems like the two of you have not had a moment to talk alone. You are awaiting his/her arrival when s/he comes in with two business friends. You say....

Fantasy rehearsals are most effective when structured on actual or anticipated experiences of the group members. This activity gives individuals a chance to practice new responses to anxiety provoking situations and to prepare themselves to deal with them effectively.

Activity: Communicating Assertiveness Through Body Posture

Time: 25 minutes

Purpose: To increase awareness of individuals' habitual body language and to provide opportunities to learn new expressive movements and stances.

Procedure. Give group members a series of assertive statements to read and react to. Each person takes a turn in acting out the statement nonverbally. Others critique the body posture, particularly noting submissive or abrasive body movement that might conflict with assertive messages. Other group members give feedback regarding the message communicated.

Sample statements for nonverbal acting:

I am annoyed at you; why are you late?
I'm interested in hearing what you have to say, but I want to finish reading this letter first.
I won't be able to come to the meeting. I have already made other plans.
I am disappointed because I expected more information from you.
I have trouble carrying the packages from the car. Would you please put the heavy items in several bags?
I'm having difficulty seeing the stage. Would you please take your hat off?
I feel especially sad when it comes time for you to leave.

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The following annotations of films were taken from About Aging: A Catalog of Films. (rev. 1977), compiled by Mildred V. Allyn, Ethel Percy Andrus Gerontology Center, University of Southern California, Los Angeles.

How Could I Not Be Among You? 28 min/color/1972/16mm

Portrait of a poet who is about to die — and he knows it. He has leukemia and he has six months to live. Film was made during his last months capturing the agony, the hope, the terror, the faith of a gifted young poet during those final days. Useful in studying the anticipated experience of death.

Journey's End 28 min/color/1974/16mm

A cast of talented and experienced actors portray leading roles in this film which stresses the importance of making essential preparations for death. The film is intended to encourage long-range planning for death by the preparation of wills, acquiring a knowledge of probate procedures and in specifying funeral arrangements. A film guide is available to assist and moderate group discussion.

Peege 28 min/color/1974/16mm

The central theme of the film is the breaking of communication barriers to reach those isolated by age and failing mental capacities. A family visits the dying grandmother in a nursing home. She is blind and has lost some of her mental faculties. The visit is awkward and when the family leaves the young grandson stays with her for a few minutes. He trys to trigger some response by whispering in her ear and touching her. His efforts succeed and when he leaves she is alone again — but now with a feeling of worth, knowing that someone cares.

Rights of Age 28 min/black and white/1967/16mm

Contrasts old people who enjoy the maximum benefits that society provides for them such as Social Security, Senior Housing, Medicare and a variety of social and recreational facilities, with those who suffer from illness, exploitation, economic deprivation and neglect. Follows one such person as she moves from an existence of isolation and apathy to promise of a more rewarding life.

String Bean 17 min/color/1965/16mm

A story of a fragile elderly woman and her love for a potted string bean plant, her plans for its incorporation into the Jardin de Tuileries, and the ultimate fate of the plant and the act of faith and optimism of its guardian.

When Parents Grow Old 16 min/color/1970/16mm

Edited from the very powerful motion picture "I Never Sang For My Father," this film addresses the issues of adult children's responsibility to aging parents and society's treatment of the elderly. What is it like to grow old in a youth-oriented society? How can we understand and accept aging as a part of the human condition? What are the limits of obligation and even compassion for our parents?

Where Mrs. Whalley Lives 28 min/black and white/1971/16mm

A study of conflict between generations. Mrs. Whalley is an aging grandmother who lives with her son's family. Sometimes it becomes a strain to hide hurt and loneliness for the sake of harmony in her son's home.

Evaluation and Assessment

The effectiveness of this or any program depends ultimately on a system of continuous evaluation that directly assesses the achievement of program objectives. The procedures that follow are directed toward that end. A variety of procedures are presented so that instructors may choose those most suitable for their purposes. Other measures may be instituted at the discretion and preference of program directors.

Objective 1: Counselors will explore their feelings about aging of self and others.
Evaluation:

1. Participation, involvement, and openness of students as they respond to structured activities should be noted by the instructor. Feedback should be provided to students from peers as well as the instructor for personal processing.
2. Students can keep an ongoing log of workshop and field experiences in which they record personal feelings about their own aging process and feelings about the older adults. They should be encouraged to note specific incidents which contribute to their expanded awareness of feelings in self and others.
3. Personal Growth Inventory (Blansfield and Lippett) can be administered in the first and last sessions of the training program.

Objective 2: Counselors will examine personal and social values and attitudes about aging and the older adult.
Evaluation:

1. In their log of workshop and field experiences, students should record personal reactions, impressions, and responses to aging and the aged. A review of the log at the end of the training period should reveal significant personal and social values and attitudes.
2. Attitudes Toward Old People (Tuckman and Lorge) can be administered to students in the first and last training session to measure changes in response to attitudinal statements regarding old people.
3. Facts on Aging Quiz (Palmore) can be administered to students in the first and last training session. This will measure knowledge about common assumptions of aging.
4. Students should be expected to complete field interviews in which they sample reactions to aging and the aged. A cross-section of the population should be tapped for this task.

Objective 3: Counselors will develop procedures and processes to help them become more sensitive to and more accurate in understanding the feelings of the older adult.
Evaluation:

1. Given written situations that involve the elderly, students should be able to demonstrate listening skills, response statements, problem solving skills, etc. Their written skill statements can be evaluated according to the standard model used in the training program.
2. Students can tape (audio and video) at least two counseling sessions with an older adult. The tapes should be analyzed to assess counseling skills. Students should be required to furnish additional tapes if counseling skills are deficient.
3. Videotaping can be used as students role play conflict situations pertinent to issues of aging. (Video- and audiotapes should be evaluated by self, peers, and the instructor.)
4. Students can be given Truax Scales for Empathy, Congruence and Positive Regard (Aspy). These scales rate performance of interpersonal functioning and can be used to identify skill levels at program entry and following the training exercises.
5. Students can plan group counseling programs for older adults, and implement these on field assignments to retirement centers or other community agencies serving the aging. In a written report they should describe and evaluate their programs and plans.

Objective 4: The counselor will explore group and individual techniques for counseling the older adult.
Evaluation:

1. In class sessions, students should plan and demonstrate to other participants, group and individual techniques for counseling the older adult.
2. Video- and audiotaping can be used to review and evaluate demonstration activities.

3. Each student should audiotape a group counseling session with the aging in which s/he acts as group leader and facilitator. This tape may be made in the field assignment.

Objective 5: The counselor will learn to identify critical issues of aging and develop appropriate skills for preventive, developmental, and remedial interventions.

Evaluation:

1. Students should interview aging clients for the purpose of identifying any critical issues and conflicts.
2. Students should present to the class reports of their interviews with supporting research data.
3. Students should be required to demonstrate skills and knowledge needed for pre-retirement counseling, sex counseling, death and grieving counseling, and other issue specific counseling.

Objective 6: The counselor will develop skills for promoting community and family understanding of problems of the older adult.

Evaluation:

1. Students should be required to survey community resources and activities for older adults and develop a referral manual.
2. Each student should develop at least one project for educating the community about needs of the elderly.
3. Each student (through field experience) should serve as advocate for at least two older clients in confronting family and/or community problems.

Objective 7: Counselors will evaluate their own response to aging clients and the effectiveness of various intervention procedures.

Evaluation:

1. Self-evaluation should be a continuous process using video- and audiotapes, processing peer and instructor feedback, and writing self-evaluations at specified intervals during the training program.
2. Students should compare data gathered from pre- and postinventories administered in the training program. They should be asked to assess areas of growth and change and develop goals for further improvement.

APPENDIX A

Attitudes Toward Old People

This scale was developed by Tuckman and Lorge (1953a). It consists of 137 items, classified into 13 categories: physical, financial, conservatism, family, attitudes toward the future, insecurity, mental deterioration, activities and interests, personality traits, best time of life, sex, cleanliness, and interference.

DIRECTIONS: Below are statements about old people. If you are in general agreement with these statements, put a circle around the Yes. If you are in general disagreement with the statement, put a circle around the No. Answer all questions. If you are not sure, guess.

Yes No 1. Old people need glasses to read.
Yes No 2. They are absent-minded.
Yes No 3. They need less food than younger people.
Yes No 4. They are in the happiest period of their lives.
Yes No 5. They spoil their grandchildren.
Yes No 6. They are kind.
Yes No 7. They repeat themselves in conversation.
Yes No 8. They cannot learn new things.
Yes No 9. They are poor eaters.
Yes No 10. They get upset easily.
Yes No 11. They prefer to live alone.
Yes No 12. They prefer to be alone.
Yes No 13. They have to be careful of their diet.
Yes No 14. They are proud of their children.
Yes No 15. They are set in their ways.
Yes No 16. They need less sleep than younger people.
Yes No 17. They are not important in the family affairs.
Yes No 18. They vote for the political candidate who promises the largest old age pensions.
Yes No 19. They are grouchy.
Yes No 20. They worry about unimportant things.
Yes No 21. They are better off in old age homes.
Yes No 22. They have to go to bed early.
Yes No 23. They expect their children to support them.
Yes No 24. They are forgetful.
Yes No 25. They are easily moved to tears.
Yes No 26. They are more interested in religion.
Yes No 27. They have many accidents in the home.
Yes No 28. They are old-fashioned.
Yes No 29. They are a burden to their children.
Yes No 30. They feel sorry for themselves.
Yes No 31. They need a nap every day.
Yes No 32. They like just to sit and dream.
Yes No 33. They are calm.
Yes No 34. They are hard to get along with.
Yes No 35. They feel cold even in warm weather.
Yes No 36. They are unproductive.
Yes No 37. They think the world is headed for destruction.
Yes No 38. They become insane.
Yes No 39. They never take a bath.
Yes No 40. They never fully recover if they break any bone.
Yes No 41. They usually live with their children.
Yes No 42. They are conservative.
Yes No 43. They are very talkative.
Yes No 44. They are hard of hearing.
Yes No 45. They are out of step with the times.
Yes No 46. They like old songs on the radio.
Yes No 47. They are stubborn.
Yes No 48. They die soon after retirement.
Yes No 49. They cannot taste differences in food.
Yes No 50. They believe in life after death.

Yes No 51. They have too much power in business and politics.
Yes No 52. They like to be helped across the street.
Yes No 53. They like to give advice.
Yes No 54. They make friends easily.
Yes No 55. They are suspicious of others.
Yes No 56. They think the future is hopeless.
Yes No 57. They worry about their health.
Yes No 58. They cannot manage their own affairs.
Yes No 59. They would like to be young again.
Yes No 60. They are touchy.
Yes No 61. They have a few friends.
Yes No 62. They never had it better.
Yes No 63. They are good to children.
Yes No 64. They have lost most of their teeth.
Yes No 65. They like religious programs on the radio.
Yes No 66. They respect tradition.
Yes No 67. They walk slowly.
Yes No 68. They feel that their children have failed them.
Yes No 69. They are selfish.
Yes No 70. They frequently quarrel with their children and relatives.
Yes No 71. They should not marry.
Yes No 72. They suffer from constipation.
Yes No 73. They hold on to their opinions.
Yes No 74. They are afraid of the dark.
Yes No 75. They like to be waited on.
Yes No 76. They spend much time in bed because of illness.
Yes No 77. They cannot remember names.
Yes No 78. They are lonely.
Yes No 79. They collect many useless things like string, paper and old shoes.
Yes No 80. They have poor coordination.
Yes No 81. They get no sympathy from their relatives.
Yes No 82. They like to play checkers or dominoes.
Yes No 83. They object to women smoking in public.
Yes No 84. They hide their money.
Yes No 85. They like to doze in a rocking chair.
Yes No 86. They like to think about the good old days.
Yes No 87. They feel tired most of the time.
Yes No 88. They are bad patients when ill.
Yes No 89. They are in their second childhood.
Yes No 90. They feel that their children neglect them.
Yes No 91. They are afraid of death.
Yes No 92. They are fussy about food.
Yes No 93. Their voices break.
Yes No 94. They prefer old friends rather than make new ones.
Yes No 95. They love life.
Yes No 96. They spend most of their time reading or listening to the radio.
Yes No 97. They would like to live their lives over again.
Yes No 98. They die of cancer or heart disease.
Yes No 99. They avoid going out in bad weather.
Yes No 100. They are untidy and careless about their appearance.
Yes No 101. They take a keen interest in politics.
Yes No 102. They frequently are at loose ends.
Yes No 103. They develop infection easily.
Yes No 104. They should not become parents.
Yes No 105. They worry about financial security.
Yes No 106. They are critical of the younger generation.
Yes No 107. They are tight in money matters.
Yes No 108. They dislike any changes or interference with established ways of doing things.
Yes No 109. They are usually supported by their children or old-age pensions.
Yes No 110. They are very sensitive to noise.
Yes No 111. They are in the way.

Yes No 112. They marry persons much younger than themselves.
Yes No 113. They are anxious about the future.
Yes No 114. They are cranky.
Yes No 115. They suffer much discomfort.
Yes No 116. They expect obedience and respect from their children and grandchildren.
Yes No 117. They meddle in other people's affairs.
Yes No 118. They are bossy.
Yes No 119. They prefer to read newspapers instead of books.
Yes No 120. They have no interest in the opposite sex.
Yes No 121. They cannot concentrate, even on simple tasks.
Yes No 122. They have a high automobile accident rate.
Yes No 123. They get love and affection from their children.
Yes No 124. They like to gossip.
Yes No 125. They feel miserable most of the time.
Yes No 126. They are careless about their table manners.
Yes No 127. They become less intelligent.
Yes No 128. They frequently talk to themselves.
Yes No 129. They do not take part in sports.
Yes No 130. They feel that young parents do not know how to bring up children properly.
Yes No 131. They die after a major operation.
Yes No 132. They are a nuisance to others.
Yes No 133. They are helpless.
Yes No 134. They are insecure.
Yes No 135. They have a high suicide rate.
Yes No 136. They are not useful to themselves or to others.
Yes No 137. They have a chance to do all the things they wanted to do.

Scoring

The attitude score is the number of "yes" responses. A high score indicates an unfavorable attitude toward older people. (High, medium, low are relative terms here and may be interpreted in respect to a group mean or ipsatively).

APPENDIX B

Facts on Aging

This quiz elicits misconceptions regarding aging and serves to stimulate class discussion. Permission to include the questions in this handbook has been granted by the author, Erdman Palmore (1977), Professor of Medical Sociology and Senior Fellow at the Center for the Study of Aging and Human Development, Box 3003, Duke University Medical Center, Durham, N.C. 27710, who has documented the correct responses in an article appearing in The Gerontologist. (Palmore, Vol. 17, No. 4, 1977.)

FACTS ON AGING

The following true and false questions are designed to assess your understanding of the physical, mental, and social facts which accompany aging. For each of the 25 items, circle either "T" for true, or "F" for false.

T F 1. The majority of old people (past age 65) are senile (e.e., defective memory, disoriented, or demented).
T F 2. All five senses tend to decline in old age.
T F 3. Most old people have no interest in, or capacity for, sexual relations.
T F 4. Lung capacity tends to decline in old age.
T F 5. The majority of old people feel miserable most of the time.
T F 6. Physical strength tends to decline in old age.
T F 7. At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.)
T F 8. Aged drivers have fewer accidents per person than drivers under age 65.
T F 9. Most older workers cannot work as effectively as younger workers.
T F 10. About 80% of the aged are healthy enough to carry out their normal activities.
T F 11. Most old people are set in their ways and unable to change.
T F 12. Old people usually take longer to learn something new.
T F 13. It is almost impossible for most old people to learn new things.
T F 14. The reaction time of most old people tends to be slower than reaction time of younger people.
T F 15. In general, most old people are pretty much alike.
T F 16. The majority of old people are seldom bored.
T F 17. The majority of old people are socially isolated and lonely.
T F 18. Older workers have fewer accidents than younger workers.
T F 19. Over 15% of the U.S. population are now age 65 or over.
T F 20. Most medical practitioners tend to give low priority to the aged.
T F 21. The majority of older people have incomes below the poverty level (as defined by the Federal Government).
T F 22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).
T F 23. Older people tend to become more religious as they age.
T F 24. The majority of old people are seldom irritated or angry.
T F 25. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now.

Coding for the 25 items above is as follows:

1. All odd numbered items are false.
2. All even numbered items are true.
3. If incorrect, items 1, 3, 5, 7, 8, 9, 10, 11, 13, 16, 17, 18, 21, 22, 24 and 25 indicate negative age bias.
4. If incorrect, items 2, 4, 6, 12, and 14 indicate positive age bias.
5. In order to arrive at an overall age bias score, subtract the percentage of errors on the negative bias items from the percentage of errors on the positive bias items. The result is the age bias score. Negative scores indicate negative bias while positive scores indicate positive bias.

APPENDIX C

Students' Questions Regarding Sex in Older Adulthood

Widowhood:

Do you miss the close loving of your partner? How do you manage this lack of closeness or sex life?

How can a woman past the age of 65 satisfy herself sexually when there are so few men around and she may be confined to her home through lack of transportation?

How can a widow or widower ease her/his frustration? Would you recommend masturbation? What other choices are there?

Do widows in their sixties and seventies engage in more masturbation than do teenagers?

Enjoyment or Frustration:

I would like to know how one would counsel or instruct a woman in the art of arousing her mate if his fear of performance is great. I can think of manual or oral stimulation but would be inhibited about bringing up oral sex with older people.

How should a woman who never particularly enjoyed sex satisfy her husband's desires as they grow older? Should she pretend, comply or what?

How do the aging feel about intercourse?

Differences in Sexual Behavior Due to Aging:

I would like some idea of the percentage of elderly that do have active sexual lives.

Am I right that there is really no difference after sixty?

Is the sex life of the over-sixty-five's similar (but perhaps less often) to what they had in their younger days?

Does intimacy actually progress with age?

Is the desire or need for companionship greater than the desire for sex?

What is the female sex drive at the so-called "menopause"?

What do older people consider sex to be?

Health and Physiology:

How does sexual intercourse affect the heart?

What are the effects of long periods of no sex on the sex drive of an older person?

General:

What are "helping professions" doing to help older people in expressing their sexuality?

How can we change attitudes of the young toward enjoyment of sex by the elderly?

What are the different outlooks of different societies regarding sex for the elderly?

MODULE VIII

THE ROLE OF PARAPROFESSIONAL PEER COUNSELORS IN WORKING WITH OLDER PEOPLE

Elinor Waters
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A special unit of the Center focuses on the needs of older people by offering group counseling, training people over 55 as peer counselors, and training service providers who work with older people in counseling skills and gerontological information.

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THE ROLE OF PARAPROFESSIONAL PEER COUNSELORS IN WORKING WITH OLDER PEOPLE

Rationale and Objectives

To respond to the increasing number of older people who both need and can benefit from psychological supports, creative methods of delivering mental health services are urgently needed. (Mental health is broadly defined here to include a sense of self-worth supported by the interpersonal and social skills which are essential to successful coping with old age.) One such creative approach to service delivery involves the use of paraprofessional peer counselors, the subject of this section. This module will concentrate on counselors working at the paraprofessional level who are themselves older people and therefore peer counselors. However, much of the content, except for the value of peer counselors as role models for older clients, is applicable to younger paraprofessional counselors.

Interest in training and utilizing paraprofessional counselors seems to be growing for a variety of reasons. These include the increasing numbers of older people in our country, the relatively small number of professional mental health workers who serve older people, the reluctance of many older people to seek professional help, and the recognition that paraprofessionals can help. Each of these will be discussed briefly.

As indicated in this syllabus, the older adult population is growing at the fastest rate of any group in the United States. In their new book, Aging and Mental Health, Butler and Lewis (1977) label as conservative the estimate made by the American Psychological Association that in 1971 at least three million people, or 15 percent of the older population, needed mental health services. Such figures do not include the large numbers of older people who suffer, not from diagnosed mental disorders, but from lowered feelings of self-worth and/or a malaise or anger toward life as a result of inability or difficulty coping with developmental problems of aging.

While the mental health needs of older people are great, the counseling services available to them are not. The lack of counseling programs for older people is probably related both to their hesitancy to seek psychological help, and to the reluctance of therapists to deal with members of this age group. Many middle-aged and older people hesitate to seek counseling help because they regard such need as inappropriate for adults ("I should be able to take care of myself"), or as indicative of illness. Moreover, the persistent myths that the elderly are tranquil, resistant to change, unresponsive to therapy, and destined to inevitable senility, keep many older people and their families from seeking help (Gaitz 1974; Tiven 1971).

Despite the increased attention given to older people in recent years, Kastenbaum's (1964) description of the "reluctant therapist" who avoids working with the elderly, still holds. In a survey of attitudes of psychotherapists at a New York City mental health clinic, Garfinkel (1975) found that the therapists held generally liberal and open attitudes toward the elderly, but they agreed on the "fact" that old people usually don't talk much. To the extent that such a belief is held by therapists, whether or not it is true (and the authors' experience certainly calls it into question), it can serve as a convenient justification for concentrating on the needs of younger people. Pomeroy (1972) suggests that therapists may avoid the elderly because old people may generate anxiety by their inevitable decline, which denies therapists the validity and reassurance that comes with younger patients' improvement.

Whatever the reasons — reluctance of older people to seek help and of therapists to provide it, shortages of trained personnel and available programs, and the high cost of help when available — it is clear that older people receive a disproportionately small share of psychotherapeutic services. Kahn (1975) states this strongly, claiming that "rather than helping older persons, the great mental health revolution has only led to their dropping out of the psychiatric system." Butler (1975) concurs by stating that most older persons never have a chance to obtain mental health services (p. 229). This seems unfortunate because, as Goldfarb (1969) notes, old people can mobilize their remaining resources and become relatively self-sufficient when they feel supported and secure in the therapeutic situation. In other words, counseling can make a difference. Interesting support for this view was provided by an evaluation of a group psychotherapy program operating in a private psychiatric hospital. Lazarus (1976) reports that this program helped older patients increase their self-esteem, fostered their resocialization, and in some cases aided their return to their former levels of functioning.

With proper training and support, paraprofessional counselors can play a valuable role in meeting the mental health needs of older people. Paraprofessionals are not only less expensive than professionals but also less threatening to many older people who may be wary of seeking psychological help. Butler and Lewis (1977) cite an NIMH study which found that paraprofessionals were used "not simply because professional manpower is unavailable but rather to provide new services in innovative ways." Furthermore, according to Butler and Lewis (1977), "Paraprofessionals have certain skills and knowledge often lacking in their colleagues . . . (they) may understand infinitely well how to provide assistance to others because of their own personal experiences and personalities." (p. 150). Clearly such inherent knowledge and skill cannot stand alone, but must be augmented and refined through systematic training as discussed below.

Paraprofessional peer counselors also serve as significant role models for their clients. They model successful aging, with the ability not only to cope with problems and losses, but to take on new roles, demonstrating the growth potential of their time of life. In a later section of this module, the experiences of the Continuum Center at Oakland University and the Andrus Center at the University of Southern California with peer counseling programs will be discussed.

This module is similar to Module VII in that both deal with a variety of counseling services for older people. It is different in that in Module VII the counseling student is presumably the trainee, whereas in this module the counseling student or practicing counselor is seen as a potential trainer or supervisor in relation to paraprofessional counselors.

MODULE OBJECTIVES

The objectives of this module are that counselors:

(1) Become familiar with the similarities and differences, values, and limitations of professionals, paraprofessionals, and peers as counselors.

(2) Become aware of the continuum of counseling services which can be provided by paraprofessionals.

(3) Learn the role of the professional counselor in relation to paraprofessionals.

(4) Become knowledgeable about selected counseling programs utilizing paraprofessional and peer counselors. and

(5) Become familiar with evaluation measures used to assess the effectiveness of counseling and/or training programs.

Content

TYPES OF COUNSELORS: PROFESSIONALS, PARAPROFESSIONALS, AND PEERS

In this section some of the similarities and differences, values, and limitations of counselors with different levels of training will be discussed. A professional counselor will be considered someone with a degree, usually at the master's level or higher, in one of the helping professions. "Professional counselors" include social workers, psychologists, and psychiatric nurses, as well as people with counseling degrees. A paraprofessional is someone who functions as a counselor, but whose credentials are less than those described above.[1] This category includes people with A.A. degrees (e.g., mental health technicians) but is not limited to that group. The special issue of the Personnel and Guidance Journal entitled "Paras, Peers and Pros" (53(4), December 1974) defined paraprofessionals as "persons who are selected, trained, and given responsibility for performing functions generally performed by professionals. They do not possess the requisite education or credentials to be considered professionals in the field in which they are working, but they do perform tasks central to the function of the agency (counseling, group work, etc.)" (p. 250). Since the term "peer counselors" generally refers to counselors who are from the same population as their clients (however that population is defined) in this module peer counselors are primarily older people. Brief mention will also be made of peer counselors from a variety of self-help groups where counselors and clients may share a problem such as widowhood, or a disease such as cancer, rather than being age mates.

Butler and Lewis (1977, p. 150) cite a number of other terms including new professionals, nonprofessionals, lay therapists, and community workers, by which paraprofessionals may be known. They state a preference "for the term 'paraprofessional' because its Greek root means 'along side of' professionals, implying a working together rather than working under other staff members."

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[1] Professionals in other fields may be considered paraprofessional counselors. For example, Oakland University's Continuum Center has a number of engineers and attorneys who function at the paraprofessional level when counseling.

In terms of similarities, both professional and paraprofessional counselors can address the mental health needs discussed earlier. Well-functioning counselors at all levels of training can help older people develop coping skills, discover new potentials for experiencing learning and growth, and exercise maximum control over their lives. In other words, they have the same outcome goals. Paraprofessionals and professionals differ in that, at least theoretically, the professional counselor is able to see things in a broader perspective than the paraprofessional. Hopefully professionals have more ability than paraprofessionals to understand the theory behind what they are doing and to apply theoretical information to practical situations.

Paraprofessionals have advantages over professionals in that they are often more aware of problems indigenous to a particular group or setting than a professional from a different background. They are often less forbidding or off-putting to clients and less likely to foster dependency. D'Augelli (1975) talks of the value of paraprofessionals as "enhancement educators." In that role, the paraprofessional operates as "a skill trainer, a facilitator and shaper of competencies . . . who gives explicit instruction in life skills." In general, paraprofessionals need more structure and supervision to perform than do professionals. Moreover, it is important not to romanticize the role of indigenous people as peer counselors. While a common background may be helpful, in itself it does not qualify a person as a counselor. Systematic training and supervision are essential.

Peer counselors, with or without formal credentials, who are age mates of their clients have advantages in that they have often shared similar life experiences. At the very least, members of the same age cohort have lived at the same time. This may lead to some similarities in values between counselors and clients and certainly aids communication and understanding. The film, What You Are Is Where You Were When (Massey 1975) documents the impact on values of growing up at various times in history.

A number of problems involved in using paraprofessional counselors with older people are mentioned here, not to discourage the use of paraprofessionals, but to alert professionals who work with paraprofessional or peer counselors to issues which may arise. These issues clearly may occur among professionals also.

Even with good training, the skills of paraprofessional counselors are typically less developed than those of professionals. This can create problems at two extremes. Paraprofessionals may get in "over their heads" and try to deal with psychological problems that are beyond their level of competency. That is why supervision in the form of a professional back-up, as well as a referral service, is important. In experience observed at the Continuum Center peer counselors did not get beyond their depth. On the contrary, they tend to be very reluctant to use their skills in counseling activities beyond their level of expertise or the requirements of the program. Problems are more evident at the other extreme, where paraprofessionals with excellent helping skills lack confidence and question their ability to be real helpers.

Paraprofessional counselors who are younger than the people they counsel may worry about their acceptance by and of older clients. Typical worries are: Will they trust me? Will they think I'm a little kid? Will they resent me, particularly if I'm in a supervisory position? A different set of concerns is represented by such questions as: Will I be comfortable with "them"? Will they bore me? Will they scare me? Do I have to be different with "them"? Answers to these questions almost never can be predicted in advance. Younger paraprofessionals should be encouraged to express such concerns and to give themselves time to establish trust with older clients and older paraprofessionals.

A less tangible concern of peer counselors, particularly those who work as volunteers, deals with issues of inclusion and exclusion with each other and in the system. In a variety of ways, some covert and overt, peer counselors often ask about their value to the program and to staff members. They may question just how they fit into the system. Competition among peer counselors can show up in a variety of ways. In training and in the programs there may be a good deal of ranking of their skills and abilities as compared to the person they perceive as the "star." Many paraprofessionals develop strong loyalties to certain staff members, frequently but not always their original trainer. Both at the Andrus Center and at the Continuum Center staff members have noticed that paraprofessional counselors sometimes experience difficulty in shifting allegiance from one supervising staff member to another.

While it does not solve the problem totally, Continuum Center staff members have found it valuable to be as explicit as possible about the role of peer counselors, stating clearly what staff can expect of peer counselors and what peer counselors can expect from staff. For example, staff members expect peer counselors to lead at least two programs a year, both to meet service needs and to keep their skills alive. Another expectation is that peer counselors inform staff about their personal needs as well as their needs for training. Peer counselors can expect staff to be available to them and to offer consultative help when needed.

Paraprofessional counselors are not the only ones who may encounter difficulties in counseling relationships with older people. It may be more of a problem for professionals since the kind of training they have had may encourage them to look for signs of pathology rather than for signs of health.

In the authors' view counselors at all levels of training who work with older people should have an opportunity to explore their own feelings about older people, aging, and death. Some instruments to facilitate such exploration and discussion are described in the evaluation section of this module.

RANGE OF COUNSELING SERVICES WHICH CAN BE PROVIDED BY PARAPROFESSIONALS

Most often we think of counseling as a formal, structured relationship between a counselor and client(s) with clear time and role boundaries. But in view of the oft-mentioned reluctance of older people to seek assistance, less-structured ways of providing counseling may be more appropriate. Kahn (1975) expressed this poignantly when he noted that while young people may see psychiatric treatment as a status symbol, old people are more apt to view it as a disgrace. Nontraditional ways of providing assistance may also offer more latitude to paraprofessional counselors who can offer a variety of services ranging from informal contact to more traditional counseling sessions as discussed below.

There are a variety of settings in which paraprofessionals can provide some kind of counseling help. (See Module IX for a more detailed description of possible counseling settings for working with the older adult.) One of the most likely settings is the senior center, which is seen as the focal point for delivery of services to community living older people. Other possibilities include: social-recreational centers which offer programming for older people; religious, fraternal, and union organizations which provide services for their older members; nursing homes which have day-care programs; and senior apartment buildings. Community mental health center, that have been mandated to provide mental health services for older people also could be an excellent site for the use of peer counselors. While crisis counseling centers and neighborhood drop-in centers may be better known among young people, they can certainly be used by older people as well.

In settings such as community mental health centers, counseling is the main function of the organization. In most of these organizations, however, counseling is an adjunct to the central focus. For example, while union groups or political advocacy groups such as the Gray Panthers are not set up to conduct counseling, trained older people within such an organization can provide that service for their peers. Many federally funded programs which are designed to serve older adults also employ older people directly as home care aides, recreational and occupational therapy aides, nutrition site personnel, or nurse's aides. While counseling is not the primary purpose of their job, training in communications and counseling skills can greatly enhance the functioning of such personnel. There are a variety of quasi-social groups such as coffee and conversation programs that can be an excellent setting for informal counseling.

In a variety of settings, paraprofessionals can provide counseling services by offering informal counseling to nursing home residents, telephone reassurance for shut-ins, telephone crisis counseling, widow-to-widow grief work, preventive mental health counseling such as the Continuum Center groups, or more formal one-to-one work such as that done at the Andrus Gerontology Center.

There are many other programs such as the Foster Grandparent program, VISTA (Volunteers in Service to America), and RSVP (Retired Seniors in Volunteer Programs) in which older people can function as paraprofessionals or professionals. Since the recipients of these services are not exclusively older people, these programs are beyond the scope of this module. They do, however, represent a viable opportunity for older people to utilize a variety of skills, including counseling.

PROGRAMS UTILIZING PEER COUNSELORS

In this section several peer counseling programs designed exclusively for older people, or which include many older people among their clientele, will be described. Where information is available, we will consider both the counseling services provided and the training program for the paraprofessional counselors who provide the service. Two programs, those at the Continuum Center of Oakland University and the Andrus Gerontology Center, will be described in some detail, and subsequently several other programs will be briefly described. Some of the principles involved in counseling older people and training peer counselors to work with them are discussed later in the section entitled "Working with Paraprofessionals: Implications for Counselors."

Continuum Center for Adult Counseling and Leadership Training,
Oakland University, Rochester, Michigan

Counseling Services for Older People. Since 1972, the Continuum Center has been offering group-counseling programs for older people affiliated with various community centers and residential settings in the metropolitan Detroit area. Some of these sites have a religious affiliation, some are municipally funded, and some have labor union backing.

The overall goal for the program, entitled Personal Growth for Older Adults (PGOA), is to help group members cope more effectively with their developmental changes in aging. The program is designed to help clients become more aware of their strengths, skills, and values; to expand their awareness of options available to them in meeting their changing life situations; and to teach clients more effective ways of communicating and relating to other people. A brief description of the content and format of PGOA as it relates to the above mentioned goals follows.

To focus on strengths and skills, a life review is done in which participants reflect on their lives and the coping mechanisms which have helped them survive. Group members are taught to give and receive feedback on how they appear to each other, an experience which enhances their sense of self-awareness and confidence. Throughout the program, people affirm themselves by relating their past accomplishments which they often overlook or take for granted. A strength acknowledgment exercise, adapted from the Human Potential Seminar (McHolland 1972), is also included to encourage self-appreciation.

To help clients identify their values, two values clarification strategies taken from the work of Simon, Howe, and Kirschenbaum (1972), the Forced Choice Exercise and the Twenty Things You Love to Do activity, are used. An expanded awareness of options comes in part from hearing other group members talk about their lives, resources and how they use them. An additional problem-solving approach is taught, and community resources are described. Throughout the program, specific communications techniques are taught and practiced by group members so that they can express themselves assertively and listen empathically. These techniques are reinforced as group members work with each other.

Each program consists of a series of seven two-hour sessions. During the first part of each session all clients meet in one group of between 18 and 40 people, where the professional counselor presents information and/or leads structured exercises related to the above goals. Following the general presentation, participants join a group of five or six clients led by two carefully selected and trained peer counselors. Within these groups, clients have an opportunity to talk about their own needs, values, and problems as they relate to the materials introduced in the large group. Typical issues discussed are relationships with family members, particularly adult children; concerns about health and dependency; feelings of loss, grief, and loneliness; and decisions about where to live and how best to use as yet empty time. This combination of large and small group work seems to be particularly effective. The large groups are well-suited to present information and the small groups to provide an opportunity for clients to personalize the information which has been provided.

The above description of content and format is meant to be illustrative. The specifics are not as important as the creation of a supportive atmosphere in which staff and peer counselors communicate their positive attitudes about aging and their belief that, with appropriate support, most older people can and should make their own life decisions. A similar atmosphere, which encourages an open expression of feelings and thoughts and a willingness to try new behaviors, is sought in the training program described below.

Training Program for Peer Counselors. In the Continuum Center model, potential peer counselors are drawn from the pool of program participants. Group leaders and project staff look for the following indicators of group leadership potential: regular attendance, ability to learn and use the program material, willingness to self-disclose, warmth and openness, ability to listen to and empathize with other group members, and a general emotional investment in the program. Group members who exhibit these characteristics are invited to attend a selection/orientation session designed to help both trainers and trainees make an informed decision about participation in training. During the session, potential trainees are asked to inverview each other and to critique their own and each other's interviews. In this way, assessments can be made of their potential skills and openness to the Center's public learning model.

For those who participate, the training program has several general objectives: (1) to reinforce in potential group counselors their existing qualities of genuineness, empathy, and nonpossessive warmth; (2) to develop their communication skills; (3) to help them become facilitators who can encourage clients to think through alternatives; (4) to increase their self-awareness and self-confidence; and (5) to teach some principles of group dynamics. The preservice training program consists of ten five-hour sessions, usually meeting twice a week. Because of the highly personal nature of the training, participation is limited to twelve trainees who work with two staff members. The training design combines didactic and experiential procedures, with most morning sessions spent in systematic, cumulative skill practice and most afternoons devoted to simulated small group discussions.

The format of skills training is based on the Carkhuff (1972) model. While Center staff drew upon many counseling theorists in developing their training model, they found that Carkhuff's approach served best as an overall framework. The explicitness of the skill development lends itself particularly well to training paraprofessionals. Trainees are systematically led through the steps of attending, observing, and reporting physical behavior of the helpees; repeating helpee statements verbatim; summarizing the gist of helpee statements and adding a feeling word; formulating a response which identifies the major feeling expressed by the helpee with a summary of the content of the helpee's statement; identifying themes in helpee statements and/or discrepancies between helpee's words and actions; and encouraging the helpee to plan action steps to improve his/her situation. Trainers introduce each skill step by demonstrating an unhelpful and then a helpful example of the skill being taught.

In the simulated afternoon group discussions, which are videotaped and then critiqued, trainees take turns being group members and group leaders. Thus they have an opportunity to apply some of the skills they learned in the mornings to a "real" group situation. To stimulate the discussions, all trainees are given some common experience (e.g., going on a "trust walk," doing a puzzle together, or hearing a lecturette on a particular approach to interpersonal communications) and then asked to discuss their feelings about the experience. After the discussion is taped, it is replayed and critiqued by trainers and trainees. As they view the tape, trainees are asked to comment on the accuracy and effectiveness of their interventions, and to suggest alternative responses for themselves. Trainees also receive feedback from trainers and from the other trainees who were members of the groups they led. In critiquing the tapes, trainers can also comment on issues of timing or pacing of responses and can underline the importance of open-ended questions. Because of the value of positive reinforcement, trainers stop the tape to comment on good interventions as well as on poor ones.

In addition to reinforcing constructive and effective counseling responses, trainers underline a variety of issues throughout the training program. Since the trainees will work in groups, trainers highlight group dynamics issues as they arise during the training. Sometimes trainers deviate from the agenda of the training group to comment on their group norms, to identify the developmental stages of their group, and to focus on interpersonal group interactions. These comments reinforce the didactic materials presented.

Training continues in a variety of ways after the preservice training program. Group leaders who are working in a group counseling program meet with the professional counselor for two hours before each group session. At this staff meeting, group leaders practice skills, discuss their concerns about their group with each other and the supervisor, and coordinate plans for the day with their coleader. Inservice days are also held approximately once a month with each session focused on a particular content area or on counseling skills, e.g., death and grief, sexuality and aging, confrontation skills, or role playing in a group.

During the past five-and-a-half years forty peer counselors have been trained, 26 of whom continue to provide leadership in Continuum Center programs in which over 500 older people have participated.

Andrus Gerontology Center, University of Southern California,
Los Angeles, California

Counseling Services for Older People. Andrus Gerontology Center at the University of Southern California has a peer counseling program as part of the broader counseling services it provides to older people in the community. The carefully trained peer counselors work collaboratively (and sometimes conjointly) with professional counselors and practicum graduate students in providing individual counseling for older people seeking help for personal and family problems.

Clients coming to the Center are generally screened by a professional staff person who makes appropriate assignments to peer counselors. The peer counselors meet with these clients on a short-term basis, that is, for a session or two. The main objectives for this short-term counseling are to provide support for the client, to help him/her clarify problems and issues, and to begin a problem-solving process. More extensive counseling generally is conducted by the graduate students. Peer counselors also do telephone interviewing, occasionally conduct intake interviews with drop-in clients, and take on the role of friendly companion to some older people. (Companions meet with clients on a regular basis or call them regularly for social contact and reassurance.) The peer counselor also makes infrequent house calls if clients calling for counseling are unable to come into the Center.

Training Program for Peer Counselors. The peer counselors at Andrus are selected from a large pool of volunteers who work at the Center doing more traditional kinds of volunteer services such as conducting tours, keeping records, and answering phones. They are chosen for training on the basis of their special interest; their own manifest skills at problem solving; their ability to listen empathically; their openness, warmth, and concern for others; and their dependability and willingness to learn.

The trainees are then involved in a 30-hour training program divided into 20 one-and-one-half-hour sessions, meeting twice a week. At the conclusion of the training program, their counseling abilities are again assessed on the basis of self and trainer evaluations.

In describing their program, Schwartz and his associates explain the objective for the training program.

> The specific aims in training peer counselors include . . . the following capabilities for functioning effectively in a counseling and/or therapeutic process.
>
> 1. To become knowledgeable enough about the process of aging so as to be as free as possible from stereotypic and mythological thinking about the behavior and the needs of older persons.
> 2. To be able sensitively to evaluate initial contacts with those requesting help so as to provide the most relevant and appropriate response.
> 3. To develop skills as a "safe," supportive and understanding listener to those who require and seek a confidante relationship.
> 4. To achieve expertise in recognizing extraordinary difficulties or limitations in interpersonal processes with counselors when they occur so as to facilitate additional help by referral when appropriate in a given instance.
> 5. To develop competence in keeping meaningful notes and records to the extent necessary for evaluating counseling procedures. (1976, p. 4)

The training is both experiential and didactic. Trainees are involved in a sensitivity training group for one-half of the training time, and lecture/practice training sessions the other half. Counseling skill practice is based on counseling techniques developed and adapted from Carkhuff (1969). Trainees practice counseling skills in pairs by role playing typical situations, i.e., a widow discussing her grief, a man who feels isolated from and angry with his family. The other trainees give feedback to the practicing helper related to the effectiveness of their help. To supplement these sessions trainees are given a comprehensive training manual which includes chapters on normal changes occurring with aging, theories of personality, and counseling techniques (Alpaugh & Haney 1978).

Supervision of the peer counselors is provided through a once-a-week, one-and-one-half-hour meeting conducted by one of the professional staff members. Professional staff members also maintain an "open door" policy, and the peer counselors are encouraged to walk in and discuss their concerns.

In addition to this supervision, inservice training days are scheduled for peers to help them continue to enhance their counseling skills. New developments will probably be forthcoming because the Andrus Center has recently received federal funding to design a special peer counselor program for minority groups.

Other Peer Counseling Programs

Some detail about the peer-counseling programs conducted by the Continuum Center and Andrus Gerontology Center has been presented because they offer formal counseling and training programs and an assessment procedure, and because they are two of the most prominent existing programs. There are a host of other organizations which use paraprofessional peer counselors (not necessarily older people) to provide services to the elderly. Some of these programs are briefly described below. This listing is only illustrative of services provided; in no way is it exhaustive.

Programs in which widowed persons help each other have been organized by a number of groups. The value of this kind of self-help group is poignantly stated by Silverman (1974):

> David Maddison, (1968) an Australian psychiatrist, did a survey of whom new widows found most helpful during the first year after their husbands died. This study confirmed that most widows felt other widows most helpful. Professional mental health workers report experiencing great discomfort when clients exhibit the depth of their despair and grief. They attribute this to the acute awareness they develop of their own vulnerability to becoming widowed. The anxiety about experiencing the intense feelings a bereaved person displays may be why clergymen back away, why families advocate a "stiff upper lip," and why another widowed person is reported to be the most helpful caregiver during this period. (p. 9)

Implied in this statement is the belief that a widow who has experienced bereavement is more comfortable with someone else's grief and more likely to see intense grief as a natural process and not a sign of emotional illness.

The development of one program conducted under the auspices of Harvard University is detailed in the book, Helping Each Other in Widowhood (Silverman 1974). Project planners reviewed research on various emotional stages of grief before deciding on which services were appropriate at various stages of the mourning process.

The same book describes in somewhat less detail the ways in which a variety of self-help groups for the widowed were established in different locations. Services offered by peer counselors in these programs include one-to-one outreach counseling, group discussions, telephone reassurance calls, information and referral services, and social events. Included in the book are suggestions on how to reach the newly widowed (e.g., through newspaper listings and referrals from funeral directors); how to establish programs and find appropriate sponsors; and how to select, train, and support volunteers.

Another source of information about this kind of service is the NRTA/AARP (National Retired Teachers Association/American Association of Retired Persons) Widowed Persons Service Program that provides guidelines for organizing a widowed persons service, resource manuals, and two pamphlets. One pamphlet is designed for recently widowed people; the other is written for couples' joint preparation for widowhood. In all of these programs, the modeling effect of peer counselors helps grieving people begin to realize they too can survive their loss.

Many other self-help groups include older people but are not designed specifically to meet the needs of the elderly population. Included here are organizations like Alcoholics Anonymous which assists and encourages members to abstain from drinking; recovery groups which help people who have suffered from mental illnesses to verbalize their fears and problems; and Reach for Recovery in which women who had mastectomies help their peers to express their feelings, encourage them to practice physical therapy, and refer them to sensitive sales people for help in selecting an appropriate prosthesis. Where older people are involved in any of these groups it is important to consider the compounding stresses which affect people who may have suffered a host of other losses at the same time, and whose physical recovery rate is apt to be slower.

Some labor union organizations also use peer counselors. For example, the United Automobile Workers of America (UAW) has a system whereby, as members retire from their local union, they join a retirees chapter. These chapters, supported by the international union but operated by and for chapter members, designate some of their members as counselors. Counselors provide a variety of information and referral services to their fellow members such as assisting them with social security and pension claims and making referrals to appropriate social agencies. One of the principal jobs of these counselors is to help retirees find their way through governmental and social service bureaucracies.

Implications for Counselors

Since these materials are intended primarily for professional counselors, some suggestions on ways in which professionals can select, train, supervise and support paraprofessional/peer counselors are provided. The attempt here is to mention some of the major issues to consider, not to offer a minicourse in supervision.

Recruitment. Recruitment of potential trainees clearly must precede selection. This can be done in a variety of ways, each of which has advantages and disadvantages. One way which may be particularly useful in starting a new program is simply to advertise through whatever media seem appropriate. Broad-based recruiting has the advantage of letting your needs be known to a large group of people and the disadvantage of possibly attracting many people who may be totally inappropriate for the training program. More rigorous screening would then be required. Another system is to use an existing group of volunteers as the pool from which trainees can be selected. An advantage of this approach is that volunteers are familiar with the organization, a disadvantage is that they may have trouble redefining themselves as counselors. A third approach is to recruit trainees from an already existing client population. An advantage here is that potential trainees have already experienced the value of paraprofessional helpers; a disadvantage is that reliance on previous clients may restrict the size of the pool from which trainees can be drawn. Combinations of various approaches are clearly possible.

Selection. Once a pool of potential paraprofessional trainees has been identified, careful selection must take place. At this stage it is important, for the sake of both trainers and trainees, that the criteria for selection be clearly identified and stated. These criteria may vary depending on the objectives of a particular program. In evaluating potential trainees it is important to consider their mental health as well as their potential for skill development. In a related discussion, Brown (1974) makes some interesting comparisons on the criteria used to select paraprofessionals and professionals. He notes that:

> The methods employed in selecting paraprofessionals have varied widely, but most programs have systematically attempted to select individuals exhibiting a capacity for empathy, warmth, and sensitivity in interpersonal relations; high self-confidence and self-regard; and the ability to accept people with values different from their own. By contrast, the selection process for professionals is typically dominated by highly intellective indexes, primarily the undergraduate grade point average and performance on the Graduate Record Examination. (p. 261)

Both mental health and potential for skill development can be assessed in a variety of ways. If potential trainees are recruited from an existing client, volunteer, or employee group, then recommendations from other peer counselors or supervisors can be exceedingly helpful. Since the emphasis in training paraprofessionals is on helping them acquire functional skills, it is important to assess their level of helping skills as part of the selection process. According to Carkhuff (1969, p. 85), "the best index of a future criterion is a previous index of that criterion." Assessments can be made by asking potential trainees to respond to simulated or real statements of helpee problems. This can be done in various ways, e.g., via paper and pencil exercises such as the Carkhuff Index of Discrimination (1969, pp. 114-123), or a critical incident case study in which potential trainees are asked to write down how they would respond to a written description of a counseling problem. Similarly, applicants for the training program can be asked to respond verbally to a problem presented on an audio or videotape, or they can be asked to interview each other in a group setting.

While trainers must have the final say as to whether or not an applicant can be involved in the training program, it is important that trainees have as much information as possible about the goals of the training program and the methods by which it will be conducted, so that they can make an informed decision as to whether or not they wish to be a part of the training program. An orientation session which serves as a microcosm of the training program is helpful in this respect, as is a clear set of guidelines that specifies what trainers expect from trainees and what trainees can expect from their trainers. If further "deselections" are to be made during the training or at its conclusion, this should be stated at the beginning with as much information as possible about why and how people will be accepted as paraprofessional counselors or asked to leave. If at the end of the training period, trainers think that any trainees still do not possess the necessary skills or that their personal problems would prevent them from being effective peer counselors, the information should be given to them as specifically and sensitively as possible. It is very important to help the rejected trainee(s) find alternate situations to use whatever skills they have.

Training. Training should provide gerontological information and include a systematic procedure for developing individual and group counseling skills. While no particular counselor-training model is suggested here, it is important for the training to focus on functional skill development. Some of the more applied models which may be helpful to students are those of Carkhuff (1969, 1972), Danish and Hauer (1973), Egan (1975, 1976), Ivey (1971), and Kagan (1972). A brief description of the common elements in some of these models appeared in an article by Waters, Fink, Goodman, and Parker (1976).

> All of these training programs have an experiential rather than didactic emphasis, which involves systematic skill practice instead of lectures, term papers, and final examinations. In each model the instructor, who is usually called a trainer or supervisor rather than a professor, introduces the trainees to functional helping skills in a sequential manner. Each of these skills is separately demonstrated, in person or on videotape. As part of the skill development, trainees are sensitized to their own as well as their clients non-verbal behavior.
>
> Because of the focus on systematic skill development rather than on a psychodynamic theory, all of the training programs can be used across a variety of theoretical approaches. Listening skills, for example, are equally essential for a behaviorally oriented or a client-centered counselor.
>
> All of the models can be scheduled on a short-term basis as either pre-service or in-service training, and all rely, to varying degrees, on video and audio-tape equipment. While

the acquisition of the skills clearly requires that the trainees function well cognitively, as well as affectively, in none of the models is it necessary for trainees to have formal preparation in one of the helping professions.

While most counselor educators are familiar with a variety of approaches to skill training, many are inexperienced in counseling or training older adults. Therefore, it may be helpful to mention some of the differences found in working with older and younger adults. Perhaps the most basic difference is that the older people have had more life experiences. Counselors need to help older people view their life experiences as a track record of coping skills, rather than as an indication that they are set in their ways. It is helpful to ask clients or trainees to identify the mechanisms they have used to survive. While such a focus on positive aspects of aging is important, it is equally important and realistic for counselors who work with older people to recognize that growing old almost always means adjusting to numerous losses. As a result, paraprofessional or professional counselors who work with older people often experience considerable sadness, and sometimes feelings of helplessness. They therefore need a support group for themselves where they can deal with their own feelings about aging and death.

While there is considerable controversy over age-related changes, it is known that speed decreases with age (Bromley 1966). This means that in counseling and training older people, counselors have to adapt their style to people who move, write, speak, and process information more slowly than is true of younger people. It also means material has to be presented more concretely, with very specific instructions and clear examples. Since many older people experience sensory losses, particularly visual and auditory, trainers need to give attention to the size of print and to the color contrast on written materials and in the facility where training sessions are conducted. They may also have to think carefully about how to position people in a training group so that those with hearing losses are directly across from the counselor in order to facilitate lip-reading. Since older people may be unable to stay in one position as long as younger people, shorter length sessions, or variety in types of activities may be important. When training older people, the counselor may need to be highly perceptive about physical needs and saturation levels of which the trainees themselves are unaware, or which in their enthusiasm they may choose to ignore. Clearly it is possible and important to encourage trainees to be aware of their own needs and to express them, but particularly in the early stages of training, trainers may have to be sensitive.

Another area for counselors to consider in working with peers and paraprofessionals of any age is the need to avoid counseling jargon. Phrases like "being in touch with your feelings," "doing a role play," or "giving straight feedback" can all be explained in other ways. While all counselees and trainees should be encouraged to ask for clarification when they do not understand words or ideas that are used, it helps when counselors try to be as clear as possible in the first place. Otherwise older people, in particular, may be prone to attribute their lack of understanding to their own educational shortcomings or to imagined or feared age-related deficits (i.e., intellectual functioning).

Supervision. Since the major role of professional counselors in relation to paraprofessionals is a supervisory and supportive one, it is exceedingly important that counselors or counseling students who expect to work with paraprofessionals be skilled in providing supervision. While a detailed discussion of supervision is beyond the scope of this module, we will identify some general principles that are important in supervising paraprofessional peer counselors. For more information on this subject, see Boyd's (1978) book, Counselor Supervision, and the article by Moore (1974), "Training Professionals to Work with Paraprofessionals."

As a starting point, supervisors need to have accurate, up-to-date information on the skill level of the paraprofessionals they supervise. This information can be obtained in part by self-report data that needs to be supplemented by tape reviews and/or observations of real or simulated sessions. Knowledge of supervisee skill levels can be useful in identifying training needs and planning appropriate remediation. Accurate assessment of paraprofessionals' strengths and weaknesses is also essential in giving good feedback and in making appropriate job placements or client referrals.

Supervisors need to be clear and consistent about the expectations they have of their supervisees. This requires a clear definition of job duties of paraprofessionals, including an understanding of their limitations and a knowledge of when they should seek help and/or make referrals. As a corollary, supervisors need to help paraprofessionals know what to expect from them and how best to use supervision. It has been found that paraprofessional peer counselors are often reluctant to ask for the help and support they need, and that they must frequently be encouraged to do so.

Assessment. An essential part of any training component must be a measurement of the effectiveness of the model or materials utilized. Before counselors would embark on conducting a training program for para/peer counselors it is hoped that they would first look to other popular programs and critically assess them for their particular strengths and weaknesses. Included in the appendices are samples of evaluation tools to encourage potential trainers to plan for evaluation and assessment before they set up their programs.

A first step in any good evaluation program is to give a statement of program objectives. The tools discussed here were adapted or designed to assess the extent to which the objectives of two specific programs were met. Therefore they would have to be adapted to fit the goals defined by other programs. The primary purpose for including them here is to highlight the need for evaluation and to suggest topics to include in an evaluation program.

Evaluation measures designed to assess helping skills, knowledge of aging, and attitudes toward aging as well as those geared toward measurement of client outcomes are other important areas requiring careful assessment and evaluation in any training program.

The first general area of assessment is that of evaluations which are part of preservice training. This, in turn, has two facets. The first facet is concerned with rating of helping responses made by trainees, either as those responses are made or from video-taped recordings of helper-helpee interviews. Usually this type of assessment is done in a time-limited (e.g., 3-5 minutes) interview session or from a time sample of a longer interview. A trained rater or raters can assess the degree of helping during the interview or subsequent to the episode by means of video-tape. The advantages of video-taped sessions include the ability to replay an interview, should the rater be unclear as to a final scale value, and the unobtrusiveness of ratings being done after rather than during the training sessions. Additionally, if the trainers are also the raters, as is often the case, they can attend to the full content of the interviews if they are video-taped rather than be concerned with assessing each one as it occurs. Audio-tapes can be used instead of video-tapes at the expense of giving up the non-verbal information. Ratings from actual interviews can be assessed via the Carkhuff rating scale (Appendix A) or a similar scale.

The second facet of preservice evaluation of helping skills concerns the rating of responses to predetermined helpee problems. Appendices B and C represent instruments of this type. Appendix B form is scored via the Carkhuff rating scale. Appendix C may be scored similarly, or according to the answer sheet which is provided. A new development in assessment of helper responses to predetermined problem situations is represented by the Jones-Mohr Listening Test (Jones & Mohr 1977). This instrument makes use of audio cassettes containing several helpee problems. Trainees listen to the problems and respond. The distinct advantage of such a measure as opposed to pen and paper tests is that it more nearly simulates an actual interview. Trainees must listen accurately and are not able to review written information before making their response.

As mentioned above, ratings can also be done from "live" helper-helpee exchange. Such a procedure has the advantage of being real and encouraging spontaneity, but lacks standardization and depends on individual helpee problems.

The second general area of assessment concerns ways of assessing attitudes toward aging and knowledge of aging. The Andrus Center makes use of written tests covering specific content areas and a final cumulative examination (Appendix D). The Ontario Welfare Council has prepared a questionnaire (Appendix E) for the purpose of assessing attitudes concerning aging along seven indices: realistic toughness toward aging, denial of the effects of aging, anxiety concerning aging, social distance to the old, family responsibility toward aging parents, public responsibility for the aged, and unfavorable stereotype versus acceptance of the aged as equals.

Finally, Palmore (1977) has developed a short, 25-item instrument (Appendix D, Module III), which assesses not only basic knowledge of the aging process, but positive and negative age bias. These three types of instruments can be used to determine acquisition of factual material or, in the case of the latter two, as initial screening tools prior to training.

The third general area of assessment is the evaluation of services delivered subsequent to training. An example of a Client Feedback Sheet (Appendix G) assesses seven general counselor traits along a five point Likert-type scale. Barrett-Lennard (1962) prepared a Relationship Inventory (Appendix H) which asks clients to rate their counselors on empathy, level of regard, and congruence. Supervisor Rating Form (Appendix I) permits a professional counselor to assess the skills and effectiveness of a paraprofessional counselor through observation of counseling sessions.

A second way of assessing counselor effectiveness is by measuring attitudinal and behavioral changes made by their clients. Appendix J makes use of a self-anchoring ladder form for the purpose of assessing attitudes concerning self-esteem, relationship with family, physical energy level, and relationships with people and activities outside the family (Appendix I). Accompanying this form is one which quantifies behaviors in similar domains (Appendix K).

A final general assessment area is that of self-evaluation. This process can be begun during training, when trainees are asked to notice and focus on behaviors which both help and hinder the counseling process, which enhance working with a co-leader, and which facilitate the learning and development of further skills. Trainees can be asked to rate themselves on the Self-Evaluation Checklist (Appendix L). After the preservice training ends, paraprofessionals can continue their self-evaluation in a variety of ways. In group supervisory sessions held each day of the program, peer counselors can be asked to identify strategies they are using which might help or hinder their clients. This serves to reinforce the former and alleviate the latter. At the conclusion of each program, peer counselors can again be asked to evaluate themselves by listing new skills they have learned, noting how they facilitated various aspects of the program, and identifying additional skills they wish to develop (Appendix M).

The self-evaluation instruments provided in the appendices are intended to be used as models only. Obviously, paraprofessionals can be encouraged to evaluate themselves in other ways. For example, the Supervisor Evaluation Form (Appendix I) could easily be adapted for self-assessment. Learning methods for self-supervision can be extremely helpful in stimulating ongoing skill development.

CONCLUDING STATEMENTS

There is a tremendous need and opportunity for increasing reliance on paraprofessional/peer counselors in meeting the mental health needs of older people. If paraprofessionals are appropriately selected, trained and supported, this can be a highly constructive move with positive implications for older people who seek help, for paraprofessionals who provide the helping services, and for professional counselors who work with paraprofessionals. Watching the personal growth and enhanced self-esteem that result from the peer counselors' investment in, and dedication to, their activities is a tremendous bonus to the professional person working with peer counselors.

The very nature of paraprofessional counseling and training requires innovative changes in service delivery and may encourage an educational developmental approach to counseling older people which focuses on prevention and growth, not just on remediation. The benefits of such a system can be widespread.

Individual/Class Activities

1. Panel Presentation. Select a group of older individuals who work as peer counselors in a community setting to address the class. After the presentation where members of the panel express their views of their lives and their work, the students and instructor should ask relevant questions. Some questions might be: What are the satisfactions and dissatisfactions you experience in your job? What kinds of changes would you make in your job if you could? For what groups do you provide services? Who supervises you? How were you trained for your work? What additional training would help you function more effectively? What kinds of impact do you think you have? How has your work affected your own lives in terms of your sense of self-esteem, your energy level, your relations with other people? (In the event it is not possible to obtain peer counselors from programs catering exclusively to older adults it may be necessary to bring in older counselors from such groups as Alcoholics Anonymous, crisis centers, etc.).

2. Role Playing. Have students "brainstorm" potential problems which might be encountered by paraprofessionals. Assign roles to students representing the paraprofessional, the professional (in a supervisory capacity), and the older client.

Role play the situations that have been identified and discuss the resolution of the problem. Suggested topics are: the insecurity of the paraprofessional about her/his capabilities, the overassuredness of a professional person (of another profession) acting in the capacity of a paraprofessional counselor, and the conflict of age between the younger counselor and the older adult.

3. Site Visits. Whenever possible, students should be encouraged to visit sites where the counseling of older persons is being conducted, such as a nursing home, a day care center, a senior center, etc. Students should have the opportunity to observe both group and individual modalities.

After observing a paraprofessional/peer counselor in an actual counseling setting, students should be required to "critique" the interaction. Criteria to be taken into account in this critique should include: empathy, training, counselors theoretical orientation and assessment and statement of the problem, client response, etc.

4. Developing a Training Program. A fictitious or real social service agency serving the elderly should be described. The state office on aging will be providing money for the recruitment, training, and use of paraprofessionals and peer counselors in this environment. Given the description of the agency and the type of older client who will be using the service, have the class develop a plan for recruitment, selection, and training of these individuals.

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Evaluation and Assessment

The following questions are intended to provide suggestions for class discussion or written essay examination to integrate the material provided in this module.

1. Compare and critique the selection and training processes employed by the Continuum Center and the Andrus Center for their para/peer training programs. Comment on strengths and weaknesses of both programs and recommend an optimal approach to the selection and training of para/peer counselors.
2. Distinguish the differences between professional counselors, paraprofessionals, peer counselors, and volunteers. For most agencies what is the hierarchy for these individuals? Are the supervisory relationships clear?
3. Discuss the advantages and disadvantages to using paraprofessionals with older adults (if relevant, distinguish between peers and younger persons).
4. Based on your counseling orientation, highlight those points of particular importance which you would want to include in a training program for paraprofessionals that will be working with older persons.

APPENDIX A

Carkhuff Empathy Scales

1.00 - Statement or question unrelated to stimulus (no feeling, meaning or direction).

1.25 - Question related only slightly to stimulus; or statement containing only a fragment (one key word) of stimulus.

1.50 - Statement related to stimulus (usually bad advice); or statement with feeling well off in intensity with no content.

1.75 - Statement containing slightly inaccurate content (missed a small piece of the meaning).

2.00 - Statement containing accurate content with wrong or no feeling; or good advice (gives reassurance and direction).

2.25 - Statement contains accurate content and feeling in the proper domain but the intensity is well off.

2.50 - Statement contains accurate feeling, but no content; or correct content with feeling in the proper domain, but the intensity is slightly off.

2.75 - Statement contains correct feeling with slightly inaccurate content (missed a small piece of the meaning).

3.00 - Statement contains accurate, interchangeable feeling and meaning.

3.25 - Statement personalizes (internalizing and external stimulus) both feeling and meaning.

3.50 - Statement labels deficit skill or behavior and the related feeling.

4.00 - Statement gives accurate feeling, deficit skill and desired goal.

4.50 - All of above responses (4.00) plus defines goal in terms of major steps toward goal.

5.00 - All of above responses (4.50) plus develops a step-by-step program to achieve goal.

Developed by Dr. Robert R. Carkhuff, 1969.

APPENDIX B

Exercises in Communication

NAME ______________________________ DATE ______________

The following are five statements which you should assume are made to you by other persons. For each statement, your task is to write what you consider to be an appropriate and helpful response to the person.

1. I retired last year and have nothing to do. I can't go back to work. I don't have enough money to really do what I would like to do, so I just hang around. My wife says I depress her.

WRITE WHAT YOU WOULD SAY.

____

____

2. It seems that everyday I get up, and something else goes wrong. My back aches more, I don't have as much pep as I used to have. Time just drags, just doing the dishes takes half my day.

WRITE WHAT YOU WOULD SAY.

____

____

3. My children are all away from home and they stay in touch, but not very often. My husband died last year, and I am all alone. No one seems to care.

WRITE WHAT YOU WOULD SAY.

____

____

4. My wife and I are having marital problems. I never thought that after 42 years of marriage and five children I could think of getting a divorce; but I'm just not happy anymore.

WRITE WHAT YOU WOULD SAY.

____

____

5. My doctor just told me I have to go into the hospital for a hysterectomy. I'm worried that at my age I won't recover, that I'll never leave the hospital.

WRITE WHAT YOU WOULD SAY.

____

____

Continuum Center
Oakland University
Rochester, Mich. 9/77

APPENDIX C

Homework Exercises

Exercise One: Responding with Content and Feelings.

Read each statement and summarize the content. List possible client feelings and then write a response reflecting feelings and content. Suggested answers for this exercise will be found at the end of the chapter.

1. "I don't know anymore. I'm just not as fast and as quick as I used to be. I can't stand the notion of having to write things down in order to remember them."

   Content:

   Feelings:

   Response:

2. "Taking care of her can be unbearable at times. There are times when I just feel like walking out and never returning. But then I can't you know, she was such a good wife to me all those years."

   Content:

   Feelings:

   Response:

3. "Without a job I feel useless. I really need to work, do something useful. But do what? I go around and around on this. I don't know what to do with myself!"

   Content:

   Feelings:

   Response:

4. "A lot you know! What am I doing here anyway? I only came here because my wife nagged at me to."

   Content:

   Feelings:

   Response:

5. "For so long I thought the kids needed me, but now I know they haven't needed me in years. What do I do now? There's no meaning to my life."

   Content:

   Feelings:

   Response:

From Andrus Gerontological Center, University of Southern California

APPENDIX D

The Final Test

ANSWER THE FOLLOWING QUESTIONS WITH A T IF THE ANSWER IS TRUE OR WITH AN F IF THE ANSWER IS FALSE.

1. There is a general slowing of behavior with advancing age. ______
2. Old dogs can't learn new tricks. ______
3. All older individuals eventually become senile. ______
4. There is no way to really know if someone has brain syndrome. ______
5. Generally, it takes longer for a man over 50 to get an erection. ______
6. There is an increased incidence of depression in old age. ______
7. Children should keep their older parent in their houses as long as possible. ______
8. With the process of normal aging, all senses tend to become duller after age 70. ______
9. After menopause, intercourse can be painful for a woman. ______
10. Sexual behavior can be influenced greatly by social and religious values and beliefs about sex and old age. ______
11. Sexual problems can be treated medically and psychologically. ______
12. Arteriosclerosis in the eye is a good indication that there is hardening of the arteries in the brain. ______
13. The older man needs the same amount of stimulation to get an erection as a young man does. ______
14. Generally, personality characteristics remain stable across the life span. ______
15. In older individuals, any intellectual decline due to normal aging is usually too small to interfere with their ability to function adequately in the world. ______
16. Night driving is more difficult for some older individuals. ______
17. Some prescribed medication can interfere with thinking and memory. ______
18. After a person recovers from the crisis of a heart attack, sexual intercourse does not endanger his health. ______
19. When someone is very depressed, he or she may often contemplate suicide. ______
20. Depression or other emotional problems can be confused with brain syndrome. ______
21. After age 20, intelligence declines. ______
22. Chronic brain syndrome is always severe. ______
23. In general, it takes an older man longer to climax than it does a younger man. ______
24. It is abnormal behavior for an older person to keep talking about the past. ______
25. Old people cannot learn. ______
26. Perceptual impairments, with normal aging, are usually so severe that they make it hard for the older person to function adequately in the world. ______
27. The highest incidence of suicide is in white males over the age of 65. ______
28. Suicide threats should not be taken seriously. ______
29. Barbituates may make an older person anxious. ______
30. Older persons generally do not have orgasms. ______
31. There is a higher incidence of impotence in older men. ______
32. Older individuals can withstand as much stress as younger individuals. ______
33. Drugs can increase memory powers. ______
34. As individuals get older (past sixty), they sometimes engage in fewer activities because they do things more slowly. ______

35. Personality types are categories which are used to identify particular sets of behaviors typically exhibited by some people.

PART II - WRITE OUT THE ANSWERS TO THE FOLLOWING QUESTIONS.

36. How can you make it easier for someone to become familiar with new living situations?

37. What can cause a marked decline in an individual's intellectual functioning?

38. Acute brain syndrome refers to cases where the symptoms are:

____

39. These are symptoms which may occur with what disorder?

a. impairment of memory;

b. disorientation as to time and/or place;

c. lack of concern about problems or, possibly, sudden unexplained shifts in behavior or mood;

d. impairment of intellectual functioning.

40. Chronic brain syndrome refers to clinical cases where brain dysfunction is

____

____

41. The three main determinants of personality which are most commonly studied are

____________________, ____________________, and ____________________.

42. What are the optimal conditions which aid visual perception in the elderly?

____

____

____

43. In older individuals, tranquilizers may interfere with ______________ and cause ________________.

44. Life review might be used to resolve the conflict which Erickson presents as the major problem besetting older adults. This conflict is ____________________ versus ____________________.

45. The four stages of grief are:

____

____

____

46. Briefly describe how you might use one of the developmental theories of personality when working with an older client.

____

____

From the Andrus Gerontological Center, University of Southern California

Answers to Final Test

1. True
2. False . . . if we can generalize from humans to dogs.
3. False . . . senility is a disease. It is not a part of normal aging.
4. False . . . Brain syndrome can be accurately diagnosed through assessment techniques.
5. True
6. True
7. False . . . it depends on the circumstance.
8. True
9. True . . . the lining of the vagina may become drier and more delicate. This can be treated by using additional lubrication and appropriate medication.
10. True
11. True
12. False . . . this is not a diagnostic sign.
13. False . . . an older man needs more tactile stimulation.
14. True
15. True
16. True
17. True
18. True
19. True
20. True
21. False . . . maintenance of IQ from 20-60. Small decline starts somewhere between 60 and 80.
22. False . . . CBS can be mild, moderate, or severe.
23. True
24. False . . . life review is a common activity in older individuals.
25. False . . . they can learn, but the learning may take longer.
26. False
27. True
28. False . . . suicide threats are a good indication that someone is seriously considering committing suicide.
29. True
30. False
31. True
32. False . . . There is biologically a lower resistance to stress in older people.
33. False . . . not yet.
34. True
35. True
36. (1) direct instruction; (2) orientation aids; (3) daily reminders.
37. (1) disease; (2) psychological problems (NOT NORMAL AGING)
38. reversible
39. brain syndrome
40. irreversible
41. (1) heredity; (2) environment; (3) self.
42. (1) high illumination without glare; (2) short periods of exposure; (3) enlarge figures; (4) great contrast between figure and background; (5) check on glasses.
43. interfere with memory and cause depression.
44. integrity versus despair.
45. (1) shock (denial and disbelief); (2) anger; (3) sorrow; (4) resolution and acceptance.

From the Andrus Gerontological Center, University of Southern California.

APPENDIX E

Opinions About People

The statements you are going to read are opinions. Anyone could agree with some of them and object to some of the others. The question is, which are the opinions with which you agree or disagree, as the case might be?

Please indicate your own judgment about each idea expressed by circling a number between 1 and 9 on the answer column. The low numbers 1, 2, 3, and 4 mean some degree of agreement and the high numbers 6, 7, 8, and 9 mean some degree of disagreement. Five then means that you have no opinion one way or another. In other words, you "measure" your opinion like the temperature on a gauge that looks like this:

← AGREE → ? ← DISAGREE →

Strongly			A little		A little			Strongly
1	2	3	4	5	6	7	8	9

Remember please: One and only one number between 1 and 9 should be circled on the answer column for each sentence. Do not stop to think too long about the statements. All that is wanted is your first reaction.

Please fill out the "Information Sheet" before continuing to the "Opinions about People" sheet.

Information Sheet

NAME ____ DATE ______________________

Sex

Male ______
Female ______

Age

(years)

Marital Status

Single ______
Married ______
Widowed ______
Divorced ______
Separated ______

Education

(Please check highest level completed)

Elementary ______
Some High School ______
Completed High School ______
Some University ______
Degree(s) ______

Occupation

(Present or former)

____

Employment Status

(At present - you may check more than one)

Working full-time ______
Working part-time ______
Not working ______
Housewife ______
Student ______
Retired ______
Self-employed ______
Employee ______

Parents

Both alive ______
Father only alive ______
Mother only alive ______
Both deceased ______

How often do you see your mother or father or both?
(Answer only if at least one parent is living.)

Living with parent(s) ______
Once a week or more often ______
1-4 times a month ______
Less than once a month ______

Friends and Relatives

Please think of the people you make a point of seeing regularly and you consider your friends. Write down the number of these friends or relatives who are in each age group.

Relatives		Friends (Non-related)	
Under 15	______	Under 15	______
15 - 25	______	15 - 25	______
25 - 44	______	25 - 44	______
45 - 64	______	45 - 64	______
65 - 84	______	65 - 84	______
85 and over	______	85 and over	______

By and large would you say that your favorite people are (check one or more):

About your own age ______
Much younger ______
Much older ______
65 years and over ______

Counseling

Please indicate whether or not you have had any counseling previous to the training.

Individual Counseling ______
Group Counseling ______
None ______

Opinions About People

1. Some people stay young at heart no matter how long they live. 1 2 3 4 5 6 7 8 9
2. Things are getting better for most people these days. 1 2 3 4 5 6 7 8 9
3. You have to be old yourself to enjoy the stories old people like to tell. 1 2 3 4 5 6 7 8 9
4. Residences for retired persons should always work out their programs and routines with the old people concerned. 1 2 3 4 5 6 7 8 9
5. The best neighborhoods are those where young families intermingle with retired people. 1 2 3 4 5 6 7 8 9
6. You can't expect other people to take care of you when you no longer can take care of yourself. 1 2 3 4 5 6 7 8 9
7. No one who is retired and over 70 should be allowed to drive a car. 1 2 3 4 5 6 7 8 9
8. The older people get, the more they think only of themselves. 1 2 3 4 5 6 7 8 9
9. You are further ahead if you always assume that everybody is out for Number One. 1 2 3 4 5 6 7 8 9
10. Most times I feel relaxed in the company of elderly people. 1 2 3 4 5 6 7 8 9
11. Old age is OK for those who are financially independent. 1 2 3 4 5 6 7 8 9
12. There is no point in talking about personal matters with people who are much older or much younger than yourself. 1 2 3 4 5 6 7 8 9
13. You can't cope with things the way you used to if you live to be a ripe old age. 1 2 3 4 5 6 7 8 9
14. Retired people are happiest in the company of people who are their own age. 1 2 3 4 5 6 7 8 9
15. Anyone could keep young if he only tried. 1 2 3 4 5 6 7 8 9
16. People in high offices aren't really interested in the troubles of the average person. 1 2 3 4 5 6 7 8 9
17. You are likely to get bogged down if you let elderly people help you with your projects. 1 2 3 4 5 6 7 8 9

18. No matter what the community can do it is up to the children to see that their aging parents have every comfort. 1 2 3 4 5 6 7 8 9
19. I cannot help feeling depressed at the thought of getting old. 1 2 3 4 5 6 7 8 9
20. You can't expect old people to exert themselves. 1 2 3 4 5 6 7 8 9
21. On the whole, people's chances in life are getting worse and not better. 1 2 3 4 5 6 7 8 9
22. When you retire you realize that the best years of life are yet to come. 1 2 3 4 5 6 7 8 9
23. You will never get old if you don't let yourself go. 1 2 3 4 5 6 7 8 9
24. It is rather sad to be still alive after all your friends are gone. 1 2 3 4 5 6 7 8 9
25. Old age pensioners have a right to be taken care of in a dignified way even if younger people must contribute their taxes to make this possible. 1 2 3 4 5 6 7 8 9
26. By and large, young people don't care about anyone but themselves. 1 2 3 4 5 6 7 8 9
27. The future is so uncertain that there is little point in thinking or planning ahead. 1 2 3 4 5 6 7 8 9
28. People who spend all they make cannot expect much when they are no longer earning a living. 1 2 3 4 5 6 7 8 9
29. All community organizations should have some older persons on their boards. 1 2 3 4 5 6 7 8 9
30. It must be quite a shock to look in the mirror and find that you are showing signs of aging. 1 2 3 4 5 6 7 8 9
31. One shouldn't try to involve elderly people in things; all they really want is some peace and comfort. 1 2 3 4 5 6 7 8 9
32. Relatives who were close to the parents in former years rightly expect the children to care about their well-being if they live a very long life. 1 2 3 4 5 6 7 8 9

Data Coding Form

The seven grids on the following page represent the format for scoring the "Opinions About People" questionnaire. For each item number in the first column of each grid, the raw score is entered from the actual questionnaire into the second column. The raw scores are the circled numbers from the questionnaire. These scores are then multiplied by the weight given in column 3 and the weighted scores entered in the fourth column. These weighted scores are then summed in the box marked "Total." This total of weighted scores represents the score for each of the seven attitudes. A summary of attitude interpretations is given on page 253.

From the Ontario Welfare Council, Toronto, Canada.

APPENDIX E

ATTITUDE 1

Item No.	Raw Score X	Weight =	Weighted Score
6		3	
11		3	
12		2	
13		3	
14		2	
28		3	
		Total	

ATTITUDE 2

Item No.	Raw Score X	Weight =	Weighted Score
15		1	
22		1	
23		1	
		Total	

ATTITUDE 3

Item No.	Raw Score X	Weight =	Weighted Score
19		4	
24		3	
27		2	
30		4	
		Total	

ATTITUDE 4

Item No.	Raw Score X	Weight =	Weighted Score
8		5	
12		2	
13		2	
14		2	
17		4	
30		2	
31		2	
		Total	

ATTITUDE 5

Item No.	Raw Score X	Weight =	Weighted Score
10		4	
18		7	
20		4	
32		7	
		Total	

ATTITUDE 6

Item No.	Raw Score X	Weight =	Weighted Score
6		1	
14		1	
17		1	
21		1	
25		8	
29		5	
		Total	

ATTITUDE 7

Item No.	Raw Score X	Weight =	Weighted Score
10		4	
14		2	
20		2	
29		1	
		Total	

From the Ontario Welfare
Council, Toronto, Canada

Brief Summary of Attitude Interpretations

ATTITUDE 1 — Realistic toughness (verging on cynicism) toward aging

To hold a tough, almost cynical, attitude toward aging (as indicated by the low scores) a person would strongly believe that old people cannot depend on anyone but themselves to face the tribulations of old age and that financial independence is the best protection from hardship.

Persons serving the aged and who display a tough, cynical attitude may tend to look down on the older person as one who cannot look after himself, hasn't prepared for his future, and might make him feel guilty for using the taxpayers' money, for taking up their time, for not expressing gratitude.

ATTITUDE 2 — Denial of the effects of aging

To strongly deny the effects of aging (as indicated by the low scores) would be to refuse to admit that changes do take place, for most people, with aging, for example, in eyesight, hearing, speed of movement.

Persons caring for the aged who strongly deny the effects of aging may tend to have too high expectations of the older person and expect him to act beyond his capabilities. On the other hand those who accept the changes that come with aging may over-react in the opposite direction and not involve the older person in any activities or decision making. Both would be detrimental to the well-being of the older person.

ATTITUDE 3 — Anxiety about aging

To have much anxiety about aging (as indicated by the low scores) reveals that the person equates old age with problems, with loss of functioning capacity, with loss of ability to look after oneself, with the belief that most old people are institutionalized.

Persons caring for the aged who are very anxious about aging may feel guilty about their anxiety and their negative feelings about old age and may be artificial in their relations with old people.

ATTITUDE 4 — Social distance to the old

Much social distance (as indicated by the low scores) denotes the belief that the old and the young cannot communicate and therefore there is no understanding between the generations.

Persons caring for the aged who display great social distance will tend to dislike and distrust older people.

ATTITUDE 5 — Family responsibility toward aged parents

To be strongly for family responsibility (as indicated by the low scores) implies the belief that the responsibility for the care of the aged rests primarily with the family — the family must look after the older members whatever the cost to family harmony, whatever their income, housing, health or other responsibilities.

Persons caring for the aged who are strongly for family responsibility may make the family feel guilty for not caring for their own and placing their parent in an institution.

ATTITUDE 6 — Public responsibility for the rights and well being of the aged versus unconcern for the aged as a group

To be strongly for public responsibility (as indicated by the low scores) is to recognize that services should be available for the aged should they require them, e.g., home help, medical care, transportation, etc.; that the aged should not be economically or socially deprived because of their age.

Persons caring for the aged and who are strongly for public responsibility may overrate their role and discount that of the family in the life of the older person. They may consider the family as a nuisance or ignore it entirely.

ATTITUDE 7 — Unfavorable stereotype of the old (as inferior) versus acceptance of the old as equals

Acceptance of the old (as indicated by the high scores) means to accept old people as individuals and to recognize there are differences among the old as among the young. At the other end of the scale, to hold a strong or unfavorable stereotype of the old (as indicated by the low scores) would be the tendency to generalize and to regard all old people as alike.

Persons caring for the aged should be aware of and take into consideration the individual differences that exist among old people — differences in socioeconomic background, experience, health, etc., and should not expect that activities which may be appropriate for one older person's life style may be appropriate for all.

From the Ontario Welfare Council, Toronto, Canada.

APPENDIX F

Circle "T" for True and "F" for False.

1. The majority of old people (past age 65) are senile (i.e., defective memory, disoriented, or demented T F
2. All five senses tend to decline in old age. T F
3. Most old people have no interest in, or capacity for, sexual relations. T F
4. Lung capacity tends to decline in old age. T F
5. Physical strength tends to decline in old age. T F
6. The majority of old people feel miserable most of the time. T F
7. At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.). T F
8. Aged drivers have fewer accidents per person than drivers under age 65. T F
9. Most older workers cannot work as effectively as younger workers. T F
10. About 80% of the aged are healthy enough to carry out their normal activities. T F
11. Most old people are set in their ways and unable to change. T F
12. It is almost impossible for most old people to learn new things. T F
13. Old people usually take longer to learn something new. T F
14. The reaction time of most old people tends to be slower than reaction time of younger people. T F
15. In general, most old people are pretty much alike. T F
16. The majority of old people are seldom bored. T F
17. The majority of old people are socially isolated and lonely. T F
18. Older workers have fewer accidents than younger workers. T F
19. Over 15% of the U.S. population are now age 65 or over. T F
20. The majority of older people have incomes below the poverty level (as defined by the Federal Government). T F
21. Most medical practitioners tend to give low priority to the aged. T F
22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work). T F
23. Older people tend to become more religious as they age. T F
24. The majority of old people are seldom irritated or angry. T F
25. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now. T F

*E. Palmore, Ph.D., Prof. of Medical Sociology, Senior Fellow at Center for Study of Aging & Human Development, Box 3003, Duke Univ. Medical Center, Durham, N.C. 27710.

APPENDIX G

Client Feedback Sheet

You have spent a good deal of time with your group leaders. For each of the following statements please place an X in the box which best describes your reaction to the leadership qualities demonstrated by the group leaders as a pair.

	DISAGREE COMPLETELY				AGREE COMPLETELY
Gave helpful feedback to the group					
Kept the group sessions directed and on track					
Communicated sincere caring (empathy)					
Shared personal experiences					
Listened well					
Made objective, nonjudgmental suggestions					
Modeled effective group skills					

Continuum Center
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12/76

APPENDIX H

Relationship Inventory

Below are listed a variety of ways that one person may feel or behave in relation to another person. Please consider each statement with reference to your present relationship with your group leader. Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please mark every one. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

+3: Yes, I strongly feel that it is true.
+2: Yes, I feel it is true.
+1: Yes, I feel that it is probably true, or more true than untrue.
-1: No, I feel that it is probably untrue, or more untrue than true.
-2: No, I feel it is not true.
-3: No, I strongly feel that it is not true.

_____ 1. (S)he respects me as a person.

_____ 2. (S)he wants to understand how I see things.

_____ 3. His/Her interest in me depends on the things I say or do.

_____ 4. (S)he is comfortable and at ease in our relationship.

_____ 5. (S)he feels a true liking for me.

_____ 6. (S)he may understand my words but (s)he does not see the way I feel.

_____ 7. Whether I am feeling happy or unhappy with myself makes no real difference to the way (s)he feels about me.

_____ 8. I feel that (s)he puts on a role or front with me.

_____ 9. (S)he is impatient with me.

_____10. (S)he nearly always knows exactly what I mean.

_____11. Depending on my behavior, (s)he has a better opinion of me sometimes than (s)he has at other times.

_____12. I feel that (s)he is real and genuine with me.

_____13. I feel appreciated by him/her.

_____14. (S)he looks at what I do from his/her own point of view.

_____15. His/Her feeling toward me doesn't depend on how I feel toward him/her.

_____16. It makes him/her uneasy when I ask or talk about certain things.

_____17. (S)he is indifferent to me.

_____18. (S)he usually senses or realizes what I am feeling.

_____19. (S)he wants me to be a particular kind of person.

_____20. I nearly always feel that what (s)he says expresses exactly what (s)he is feeling and thinking as (s)he says it.

_____21. (S)he finds me rather dull and uninteresting.

_____22. His/Her own attitudes toward some of the things I do or say prevent him/her from understanding me.

_____23. I can (or could) be openly critical or appreciative of him/her without really making him/her feel any differently about me.

_____24. (S)he wants me to think that (s)he likes me or understands me more than (s)he really does.

_____25. (S)he cares for me.

_____26. Sometimes (s)he thinks that I feel a certain way, because that's the way (s)he feels.

_____27. (S)he likes certain things about me, and there are other things (s)he does not like.

_____28. (S)he does not avoid anything that is important for our relationship.

_____29. I feel that (S)he disapproves of me.

APPENDIX H — Continued

_____ 30. (S)he realizes what I mean even when I have difficulty in saying it.

_____ 31. His/Her attitude toward me stays the same: (s)he is not pleased with me sometimes and critical or disappointed at other times.

_____ 32. Sometimes (s)he is not at all comfortable but we go on, outwardly ignoring it.

_____ 33. (S)he just tolerates me.

_____ 34. (S)he usually understands the whole of what I mean.

_____ 35. If I show that I am angry with him/her, (s)he becomes hurt or angry with me too.

_____ 36. (S)he expresses his/her true impressions and feelings with me.

_____ 37. (S)he is friendly and warm with me.

_____ 38. (S)he just takes no notice of some things that I think or feel.

_____ 39. How much (s)he likes or dislikes me is not altered by anything that I tell him/her about myself.

_____ 40. At times I sense that (s)he is not aware of what (s)he is really feeling with me.

Relationship Inventory Data Coding Form

In order to score the relationship inventory properly, the following coding form is provided. The relationship inventory measures a person's ability to demonstrate to another person her/his capacity for (1) level of regard -R, (2) empathy -E, (3) congruence -C, and (4) unconditionality of regard -U. Both positively and negatively scaled items on each of these four areas are included on the inventory. In order to arrive at correct total scores for each relationship area, the following steps should be taken:

STEP 1 - Multiply the sign of each relationship area (e.g., + R, - E, etc.) from the coding form below by the score obtained from the client for each item. Thus, a negative score on a negatively worded item would indicate a positive view of the helping person.

STEP 2 - For each of the four relationship areas, sum the item scores obtained from Step 1. This provides a measure of competence in each area for each helping person rated. Higher scores represent increased levels of competence; lower scores indicate areas of weakness.

R+ 1.
E+ 2.
U- 3.
C+ 4.
R+ 5.
E- 6.
U+ 7.
C- 8.
R- 9.
E+ 10.
U- 11.
C+ 12.
R+ 13.
E- 14.
U+ 15.

C- 16.
R- 17.
E+ 18.
U- 19.
C+ 20.
R- 21.
E- 22.
U+ 23.
C- 24.
R+ 25.
E- 26.
U- 27.
C+ 28.
R- 29.
E+ 30.

U+ 31.
C- 32.
R- 33.
E+ 34.
U- 35.
C+ 36.
R+ 37.
E- 38.
U+ 39.
C- 40.

From G. T. Barrett-Lennard, 1962.

APPENDIX I

Supervisor Evaluation Form

Adult Counseling Center
Andrus Gerontology Center
University of Southern California
Los Angeles, California 90007

Evaluation Prepared by: ____
(Name of Supervisor)

Title: ____

Date: ______________________

Specific Assignments of Student (include caseload) ______________________________
____
____
____
____

INSTRUCTIONS: Write in appropriate number for each factor:

(1) Poor; (2) Below average; (3) Average; (4) Above average; (5) Outstanding

Please comment on the student's performance wherever possible.

____
____

I. PROFESSIONAL PERFORMANCE AND SKILLS
(Note: Each score in this category is rated double points.)

A. Good judgment in making assessment of counseling potential of older clients.

B. Can formulate therapy/counseling goals which are appropriate and relevant to the older client.

C. Can effectively differentiate the special needs and interests of the older client and other family members.

D. Is able to establish and maintain good rapport with older clients.

E. Handle "information and referral" for older clients and families appropriately.

F. Shows awareness of and sensitivity to environmental factors affecting older adults.

G. Deals with older client's support (or lack of) support systems.

H. Moves toward relatively specific goals in counseling older adults and their families.

I. Is able to confront older clients, yet takes them seriously, treats them with dignity.

II. PROFESSIONAL DEVELOPMENT

A. Can accept and utilize supervisor's suggestions.

B. Willingness to learn and change professionally.

C. Not dependent on supervisor — uses supervisor as consultant.

D. Keeps self aware of new developments in gerontology.

E. Makes attempt to understand and utilize community resources appropriate to older persons.

III. RELIABILITY OF PERFORMANCE

A. Follows rules (reporting, etc.) of the Center.

B. Is on time; keeps appointments.

C. Sensitive to co-workers; maintains good working relationships.

D. Willing to assume responsibility where appropriate; can initiate.

Additional Comments:

A. What are specific strengths of the student:

B. In which specific areas would he/she benefit from additional work or training.

C. Recommendations to student:

IV. Counselor Qualities. Please rate counselor on the following scales, according to the Carkhuff ratings (1 to 5).

_____ respect
_____ empathy
_____ genuineness
_____ self-disclosure
_____ confrontation
_____ immediacy of relationship
_____ counselee self-exploration
_____ personally relevant concreteness or specificity of expression

V. Review with student ______________________________
(Date)

B. Student's Suggestions:

______________________________ (Signature of Supervisor)

______________________________ (Signature of Student)

APPENDIX J

Personal Growth — Older Adults

A Profile of Me

NAME ______________________________ DATE ______________

Here are four ladders that will help you describe yourself. On each one, suppose that the top of the ladder represents the highest possible level and the bottom represents the lowest possible level. Put a "✓" on the rung of the ladder which shows where you see yourself at the present time.

MY OVERALL FEELINGS ABOUT MYSELF (SELF ESTEEM)

10
9
8
7
6
5
4
3
2
1

MY RELATIONSHIP WITH MY FAMILY

10
9
8
7
6
5
4
3
2
1

MY PHYSICAL ENERGY LEVEL

10
9
8
7
6
5
4
3
2
1

MY RELATIONSHIP WITH PEOPLE AND ACTIVITIES OUTSIDE MY FAMILY

10
9
8
7
6
5
4
3
2
1

GOAL:

APPENDIX K

Feedback Sheet — Older Adult Project

For each of the four preceding ladders, we are interested in some of the behaviors which may help you decide which level you are on. Please comment briefly on the questions below.

MY OVERALL FEELINGS ABOUT MYSELF

Describe those things which led you to mark the level that you did.

MY PHYSICAL ENERGY LEVEL

Describe the things that you do around your home and neighborhood each week. (Please indicate the number of times these things are done.)

Work: ______________________________

Cooking: ______________________________

Laundry: ______________________________

Shopping: ______________________________

Cleaning house: ______________________________

Hobbies: ______________________________

Recreation (Movies, plays, etc.): ______________________________

Use of community centers, retiree centers, etc.: ______________________________

Voluntary work: ______________________________

Church work: ______________________________

Driving: ______________________________

MY RELATIONSHIP WITH MY FAMILY

Describe the types and number of contacts you have with members of your family each week.
(Telephone calls, letters, visits, etc.)

Children: ______________________________

Grandchildren: ______________________________

Brothers & Sisters: ______________________________

Other Relations: ______________________________

How many relatives live in the immediate area? ______________________________

MY RELATIONSHIP WITH PEOPLE AND ACTIVITIES OUTSIDE MY FAMILY

Describe the type and number of contacts you have with friends, neighbors, etc. over the course of a week.

Friends: ______________________________

Neighbors: ______________________________

Others (New friends, casual acquaintances, etc.): ______________________________

APPENDIX L

Self-Evaluation Checklist — How I'm Doing

	SATISFIED	NEEDS IMPROVING	NOT SURE
1. I COME ON TIME			
2. I ATTEND EVERY SESSION			
3. I KEEP A LOG			
4. I ALLOW MYSELF AND OTHERS TO MAKE MISTAKES			
5. I CAN EVALUATE MY STRENGTHS AND WEAKNESSES			
6. I CAN GIVE FEEDBACK			
7. I CAN HEAR FEEDBACK			
8. I AM ATTENTIVE			
(a) I LEAN FORWARD			
(b) I HAVE GOOD EYE CONTACT			
(c) I OBSERVE			
(d) I LISTEN CAREFULLY TILL THE SPEAKER IS FINISHED			
9. I CAN GIVE A REFLECTIVE RESPONSE			
10. I AM AWARE OF MY OWN FEELINGS			
11. I SHARE MY OWN FEELINGS			
12. I SPEAK SO OTHERS CAN UNDERSTAND ME			
13. I UNDERSTAND THE MATERIAL WHICH IS PRESENTED			
14. I AM AWARE OF THE DEVELOPMENTAL STAGES OF A GROUP			
15. I ASK QUESTIONS WHEN I NEED MORE INFORMATION			
16. I CAN OPEN A GROUP			
17. I CAN CLOSE A GROUP			
18. I AM AWARE OF MY CO-LEADER			
(a) I PLAN AHEAD WITH CO-LEADER			
(b) I COMMUNICATE WITH CO-LEADER DURING OUR GROUP TIME			
19. I LOOK CUTE ON TV			

Continuum Center, Oakland University, Rochester, Mich. 9/76

APPENDIX M

Group Leader Self-Evaluation Sheet

NAME ______________________ PROGRAM ______________________

DATE ______________________

1. What did you do that facilitated intrapersonal exploration in your group? What hindered it, if anything?

2. What did you do that facilitated working with your co-leader? What hindered it, if anything?

3. What did you do that facilitated clinicing? What hindered it, if anything?

4. What did you do that facilitated large group activities? What hindered them if anything?

5. What new skills did you learn that you have?

6. What skills did you identify that you would like to improve on?

7. What did you do that facilitated working with the "sitter-inner?" What hindered it, if anything?

8. What, if anything, did you learn about yourself during today's evaluation?

MODULE IX

PROGRAMS AND ENVIRONMENTS FOR COUNSELING OLDER ADULTS: AN OVERVIEW

Paul A. Kerschner

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PROGRAMS AND ENVIRONMENTS FOR COUNSELING OLDER ADULTS: AN OVERVIEW

Rationale and Objectives

The National Institute of Mental Health indicated as late as 1972 that only 4 percent of all clients using the services of community mental health centers was over the age of 65 (NIMH 1974). While there were and still are a number of reasons why older people remain outside of the counseling environment, it is suggested that the setting in which the service is offered plays a significant role in their decision.

In order to "open" the counseling door to the older population two strategies were employed during the past twenty years. The first of these, not a subject for this syllabus, was to convince the population that a decision to utilize the traditional counseling setting was not something to be hidden but rather a rational and normal response to a pressing concern. This "campaign" was highly successful, resulting in an entire generation that freely and openly discusses its counseling sessions. Perhaps the best example of this strategy was used in the mid-1960s by the Peace Corps during their training and selection program for incoming volunteers; each trainee was assigned a counselor who spent an hour a week over the three-month period attempting to assess the suitability of the individual for a two-year stint overseas. There was little resistance by the trainees to this process; many seized the opportunity to work through long-held problems and concerns.

The second strategy used to institutionalize counseling as one of several preventive health programs was to significantly expand the number and types of settings where counseling might take place. The decision to move in this direction resulted in numerous consumer or user surveys. Subsequent demographic profiles of client groups revealed a young and relatively wealthy user population, relying on traditional settings. As this module indicates, public and private resources have been expanded to cover nontraditional settings.

During the past five years, various programs and projects around the country have verified the importance of multiple settings for the delivery of counseling services to older adults. This module discusses the importance of the "setting" issue and describes in some detail the type of programming which takes place in each and some of the possible consequences and spin-offs that can be anticipated. To a counselor of older persons, the issue of environments is critical for your program success. Developing counseling programs without concern for where they will take place is like training astronauts without concern for space and space vehicles.

Through the use of this and the accompanying modules, future counselors will hopefully enter the field relatively free of stereotypes and willing to experiment with a variety of new environments. If this should occur we will make great strides forward in our attempt to maximize counseling opportunities for America's older citizens.

The information contained in these pages seeks to meet the following objectives:

(1) To provide instructors with data regarding the variety of settings where older adult counseling can and does take place;

(2) To sensitize the reader to the appropriateness and utility of nontraditional service settings;

(3) To identify and discuss the benefits of specific settings and program formats for both provider and consumer;

(4) To identify the degree of "fit" between the training setting and the service environment;

(5) To inform the reader as to the relationship between setting and consumer "mix," such as ethnicity, income and age.

Content

COUNSELING ENVIRONMENTS

There are most likely an infinite variety of settings in which older adult counseling might take place. The following eight cases exemplify arenas where counseling has been undertaken and where data exist as to success and failure. While the major settings discussed will be familiar to many, the reader is urged to delve further into these cases to explore new and heretofore unexamined possibilities.

Four- and Two-Year Educational Institutions

Today's higher education institutions are witnessing an unprecedented shift in the age distribution of the student population, a trend which is expected to continue. With the exception of the influx of World War II veterans, recent high school graduates have traditionally comprised the major portion of the student body of higher education institutions. Students past the age of 25 were few and those past 60 were quite rare. Recently, however, the student body is becoming considerably more heterogeneous with respect to age; a smaller proportion of the traditionally aged student population has been enrolling while at the same time an increasing proportion of nontraditionally aged students has been pursuing higher education activities (Berendzen 1974; Gleazer 1974).

As the educational institutions of this nation continue to "gray," the role of the counselor in institutions of higher education increases in importance. S/he has a multiple role to play within the institution including but not limited to:

1. a faculty member in a four-year and graduate degree program training both younger and older persons as professional counselors;
2. a counselor in a counseling program developed and designed specifically to accommodate older adults, students, and nonstudents;
3. a faculty member in an AA degree program training younger persons as paraprofessionals and training older adults as peer counselors;
4. a counselor in an already existing counseling center who can address the needs--social, personal, academic, vocational, and financial — of the older adult students both in two- and four-year institutions.

Four-Year University or College

This setting has long been used as a training ground for master's and doctoral candidates in the counseling professions (counselor education, psychology, social work, marriage and family). Depending on the licensing and certification requirements of their discipline and their state, students are required to spend hundreds of hours working with clients.

Traditionally, these departments have provided a wide variety of settings in which clients might be seen. Included have been mental health centers, crisis centers, elementary and secondary schools, hospitals, and most significantly, university-based counseling centers. The latter setting includes student mental health centers, college counseling centers, career and placement centers, child guidance centers, and psychological research centers among others.

Prior to the 1970s, few if any older adults were seen at university clinics. A prevailing school of thought argued that "counseling is counseling" regardless of the age of the user, and other factors also contributed to the dearth of elderly clients: lack of transportation, perceptions of a university as solely the territory of the young, fear of being used as a research subject, and a reluctance to admit to having a problem (Ethel Percy Andrus Gerontology Center 1977). Furthermore, some university counseling centers do not open their doors to nonstudents.

The advent of increased governmental involvement in issues of aging (Older Americans Act, Medicare, Supplemental Security Income Program, and the National Institute on Aging), the return of more older adults to the postsecondary educational setting and the rise of university training programs in the field of gerontology (University of Southern California, Duke University, Brandeis University, University of Michigan-Wayne State University, Portland State, University of Nebraska at Omaha, and many others) spurred interest in counseling the older adult. It was evident, however, from the experience of non-age specific university clinics that merely opening an adult counseling program would not insure a client flow. Clearly, an older adult counseling program would require a unique and carefully planned approach to avoid a what-if-I-gave-a-party-and-nobody-came situation.

The most important rule to be followed when organizing a university-based program is: Universities do not exist to provide services as an end unto themselves. Services should be viewed as the vehicle for the improvement of training and research. Unless this rule is strictly adhered to, one of two situations results: community agencies already delivering the services become provoked over turf issues, or agencies use the existence of the university program as an excuse not to get involved. When discussing whether a university or college wishes to move into this area, the following questions must be asked in terms of the above rule.

1. Is service ancillary to training and research?
2. Are there community agencies offering the service?

3. Is the program research-based, developing a model for wider use?
4. Will the program initiate a spin-off in the near future to an appropriate community agency?

To date, university projects have adhered to these guidelines with their decision made somewhat easier to reach by the lack of community agencies operating similar programs.

There are several elements that should be part of any comprehensive older adult counseling scheme. The example used as a base for the following discussion is that of the Adult Counseling Program at the Andrus Gerontology Center at the University of Southern California, although other programs exist that follow this or similar approaches.

While the program discussed below is that of a categorical aging project, all-university clinics may desire to initiate selective programming for the older adult. Either approach is appropriate, although highly dependent on staff and financial resources.

1. There must be close linkages with all departments of the university engaged in counseling programs. The USC model is linked closely to counselor education, psychology, and marriage and family with a somewhat weaker tie to social work (on the MA and PhD levels).
2. The older adult counseling project must be approved as a practicum site for the counseling hours required of the students.
3. The counseling hours must be tied to a comprehensive curriculum of classroom teaching and both individual and group supervision sessions.
4. The program must be staffed by professional counselors capable of providing the necessary supervision.
5. There must be an exacting procedure for the screening of students to determine eligibility.

Once the training component has been established, attention should turn to the actual service provision (actually these phases are planned and implemented concurrently). An initial decision must be made as to the age of the clients to be served. While USC used the 60+ to avoid any problems concerning the use of earmarked public funds, they also see younger family members as long as there is an older adult present somewhere in the situation (this is referred to as the "closet elderly" rule). Having determined age eligibility, the next issue is that of fees. As these programs are attempting to serve those individuals often left out of the service system they tend to have limited resources. While there are those who argue that charging a fee is less paternalistic, the USC decision was to offer the service free and merely state that any donation would be gratefully accepted. (Obviously, such a decision requires either public or private operating funds or, at the very least, student stipends.)

Advertising the service to the community is the next step in the process and should be viewed as a critical variable. Issues to contemplate include what one calls the program (e.g., "mental health counseling" could serve to "threaten" some potential clients); what form of media one uses (USC has had considerable success with public service radio spots); the geographic area from which you seek to draw clients; and the actual content of the message.

The final step in the service element is the actual delivery. Once a client has entered the system (by phone, referral, or walk-in), s/he is initially seen by a peer counselor (refer to Module VIII). Once the intake data have been received, the client is interviewed by a counseling supervisor who makes a determination as to the level of the problem. The client is then tracked to the appropriate counselor: peer, student, professional. The number of sessions is, of course, determined by the severity of the problem and the success of the counseling.

The research component of the four-year university program is critical in that it allows for continuous monitoring of the operation while often fulfilling the requirements of the funding agency for evaluative data. Research should be conducted in the areas of: client mix (are certain population groups more or less prone to take advantage of the service?); counseling approaches (e.g., are group sessions better received than one-to-one counseling sessions?); societal barriers to utilization (e.g., are transportation, income, and setting obstacles to service?). In order for such research questions to be answered, a comprehensive record keeping system must be initiated at the very beginning of the program. In addition to their research value, thorough records can be of great assistance should questions ever be raised regarding the treatment of any individual.

Two-Year Institutions: Community Colleges

During the past several years many older adults have become involved in classes and activities sponsored by two-year institutions, and gerontology has moved in a significant way into the curriculum and programming of two-year institutions. These colleges have developed a two-track system whereby a graduate can either move to a four-year setting to obtain a BA or BS, or receive an AA and move directly into the work setting. This dual system provides an optimal setting for an older adult counseling program. For students desiring the AA as a terminal degree, a paraprofessional counseling program offers a *variety of opportunities.*

Often a two-year older adult counseling program is based in a unit usually referred to as a community or human services division. These programs grew up in response to the variety of services required by communities, including career counseling, child care services, continuing education, and specialized courses such as crime prevention. Given the increasing number of middle-aged and older students utilizing the two-year college, the existence of an older adult counseling provides a natural 'fit'' between institutional capability and client requirements for training and service. The placement of the program within a community services component ensures that the project will cross all schools and departments, as well as gain external legitimacy.

The first question that must be answered by those planning the program and the curriculum is what end product will result from the proposed training. It should be made clear that the graduates of the program will not be professional counselors, but rather have a status akin to those individuals in the medical field known as physician assistants. In their career placements they would be working with professional counselors in the settings described here and elsewhere in this syllabus. They would also be excellent prospects as directors of facilities such as senior centers, park and recreation senior programs, and nursing home activity programs. Their training and exposure to the counseling needs of the elderly will serve to increase their sensitivity and allow them to serve as enablers and facilitators for linking the older person with an existing community counseling service.

Once the end product has been identified, the next step is to determine the curriculum. Besides the general education requirements, there should be courses in life-span psychology and sociology, an overview course on counseling, and a social work course on interviewing. The two-year program should be realistic. One cannot expect to offer extensive course options given the few electives available to the student. In an effort to compensate for the low number of courses, the community college programs have developed a strong field component. As in the four-year program, the clients seen by the older adult program of the community colleges have problems that cluster around career issues as well as the more critical emotional arena.

What is most important to keep in mind when organizing an older adult program in a two-year college is the notion that such programs are supportive of, not competitive with four-year programs. Indeed, a counseling program may be an ideal model for joint ventures between the two institutions whereby the graduates of each work side by side in the work setting.

Already Existing Counseling Centers: Two- and Four-Year Institutions

The existence of trained counselors capable of reaching out for and to the older adult is a critical service need. The older student returning to the college campus faces a variety of traumatic episodes: A predominantly youth-dominated environment; self-doubts as to the wisdom of a return to an academic environment; potential difficulties in meeting college requirements; and the normal fears of individuals contemplating second or third careers. Through the mechanism of the counseling setting, many of these fears can either be ameliorated or removed entirely. Ways in which counselors can intervene include: assistance with orientation and schedules, housing location, financial planning, ego building, and study assistance. The above intervention strategies represent a wide definition of counseling and are not limited to mental health aspects.

Multipurpose Senior Centers

Perhaps one of the most promising sites for older adult counseling, senior centers, are springing up all over the nation. Multipurpose senior centers have been around for many years, beginning under the auspices of nonprofit community agencies such as Jewish, Catholic, and Protestant social service groups and moving, during the 1950s and 1960s into the arena of park and recreation programs. During the past three years, the Federal Government has entered the field through the funding of Title V (recently merged into TITLE III) of the Older Americans Act, which provides capital building and renovation monies for senior centers (NCOA, 1977).

It is important for the reader to be aware of the changes that have taken place in senior centers, changes that have provided an optimal environment for older adult counseling projects. In the early years of these centers, prior to the 1960s, the sites served to provide a haven where the elderly poor could receive some financial and occasional nutritional assistance. Over the next decade, there was a heavy shift toward recreation, and a variety of activities (cards, dancing, trips, lectures, etc.) were provided for the elderly in the immediate neighborhood. This recreational and activity focus has prospered and endured into the 1970s, but with one major addition. Today's multipurpose senior center is both a program site and a service site. The older person entering a center such as Baltimore's Waxter Center, San Francisco's Senior Center, or Hollywood's Andrus Older Adult Center can take part in a wide range of activities including exercise physiology programs, legal services, Title VII nutrition programs, memory clinics, and adult counseling programs. Such a major addition to the programs being offered has called for the training and use of individuals capable of delivering quality services. The older adult counseling programs typify this need for trained personnel.

The majority of older adults attending multipurpose senior centers fall into the low and lower middle income categories. There are responsible critics, (e.g., gerontologist Elias Cohen) who argue that the truly needy elderly referred to as the "hidden elderly" are not being served by the senior center network (Cohen 1973). A great proportion of these seniors have long been absent from the social service network by either choice, income, or transportation. As was noted earlier in this module, today's older population tends to be very reluctant to seek out counseling due to a perceived stigma around the issue of mental health. Yet many of these people have problems around issues of role, physical health, sex and marriage, family, and income that could be ameliorated, given timely counseling assistance (Berger 1977). In order to determine the type of counseling program appropriate to a senior center setting, we must look at the center environment.

The majority of centers are run by a very small paid staff supplemented by large numbers of volunteers and by outstationed (employed by one agency, but physically assigned to another) employees from community agencies. The directors and staff of these centers operate on very limited budgets and thus are restricted in the number of professional services they can offer. They tend to play a coordinating and facilitating role, seeking to link the individual with a community service able to meet his or her needs. Thus, linkages are made with existing counseling agencies in the community (e.g., community mental health centers), and university or two-year college students and peers provide services on a circuit rider basis.

In the case of community linkages, several centers such as those in Los Angeles have coordinated their efforts through a local Area Agency on Aging. The AAA has provided some money to the university counseling program, which in turn assigns some staff people on a consultant basis to the senior centers (Berger 1977). These counselors (professionals, students, or peers) engage in a two-part program to sensitize senior center staff to the existence of counseling problems among their clientele and to operate group counseling sessions in an effort to "educate" seniors as to the appropriateness and desirability of counseling as a problem-solving method.

The sensitization of senior center staff takes the form of a lecture series on psychological, sociological, and physiological issues of later life, drawing upon the expertise of either university faculty or professionals in the community. Following the lecture series, the center staff is trained in interviewing and intake methods that allow them to "scan and monitor" their clientele for mental health problems. The last part of this sensitization program is to link the senior center staff with existing community agencies by having agency personnel talk to the staff, explain the resources available, and indicate the methods by which the senior centers can easily tap into the agency service. This sensitization and linkage program is vital for the senior center to function on its own once the university or community college presence has been completed or withdrawn.

The second aspect of the program involves the operation of group counseling and occasional one-to-one counseling. Through close cooperation with senior center staff, arrangements are made to have a counseling series once or twice a week. This counseling series can be called "Gerontology and You," "Good Health in the Later Years," "Problem Solving in Old Age," or whatever title appears to be the least threatening given the composition of the client group. Run by a graduate student or peer counselor, these sessions take the form of group discussion where participants are encouraged to share problems and issues which are then addressed by the counselor and other group members. Over time, the participants begin to lose their defensiveness and willingly participate in the counseling program. It should be noted that terms such as mental health counseling or therapy stir up considerable alarm and should be avoided where possible.

Long-term Care Facilities

There is a variety of institutions for the long-term care of older adults. This section discusses skilled and intermediate facilities wherein the individuals need relatively constant nursing attention and suffer from at least two chronic disabilities (also see modules III, V-B & V-C).

The reimbursement that comes from either Medicare or Medicaid barely covers the minimum care required (Kerschner & Hirschfield 1975), and what monies do exist go to physical care personnel (nurses, doctors, physical therapists) and little goes to mental health personnel. While most facilities do have a part-time social work consultant, these individuals spend the greatest proportion of their time on issues of discharge planning and consultation around family matters. In recent years a new type of employee has been added, an activity director. These individuals operate a variety of programs including games, lecture series, special events, and the like. The majority of them have not been trained in any form of counseling techniques. As a result of excellent studies conducted by the Veterans Administration Hospital in Tuscaloosa, Alabama, many facilities are now engaged in what is called Reality Orientation (Taulbee & Falsom 1966). While an extremely valuable tool, reality orientation is most successful in addressing the problems of the disoriented and confused patient. It is not intended as a counseling technique for the oriented but troubled patient.

The long-term care environment is ripe for some form of adult counseling around problems of institutionalization, loneliness, depression, anomie, and similar ailments. Today's enlightened facility staff has recognized this need and moved to develop counseling programs in several ways, including the use of counseling field work students from local institutions of higher learning and through the training of existing staff. Many sites are now offering their facilities as training arenas for students desiring to enter the long-term care field, including counseling students.

In order for such a program to be successful, it must ensure that trained supervisors are present at the facility (either a staff MSW or a supervisor from the counseling program itself), obtain permission from residents or families to offer the service to a client, confirm that the facility has proper insurance coverage should a malpractice question be raised, provide private space where counseling can take place, and obtain clearance from the facility to avoid scheduling conflicts.

The response by patients and families to this type of program has been excellent and in many cases the results extremely gratifying. The individuals (students, professionals, peers) stationed in long-term care facilities must have additional training over and above their basic or core counseling courses. They must receive training in the particular issues surrounding the institutionalized older adult. The problems facing this population are, in many cases, significantly different from those of community elderly.

The second approach to long-term care counseling is the training of existing facility personnel. It appears that the personnel most appropriate to receive such training are the social workers, nurse practitioners, and activity directors. The intent of this continuing education is not to turn out professional counselors, but rather to arm these on-line personnel with the techniques necessary to recognize and address in a timely fashion the mental health problems of their patients. Depending upon the severity of the problem it can either be handled by the staff, assigned to a university counselor should such a program exist, or referred out to an appropriate community agency.

The continuing education training to be provided to these staff members should include sessions in the following areas: psychology of aging, sociology of aging, the institutionalization phenomenon, interviewing techniques, and intervention strategies. Once again, such training can be received from a counselor in a local university or community college or from professionals working in community agencies or facilities. Given that five percent of today's over-65 population is institutionalized, the need for counseling programs is both timely and critical (Weg 1977).

Community Mental Health Centers

Initiated and perceived as a panacea for the many problems facing the delivery of mental health services, community mental health centers have fallen far short of the ideal in the case of the aged. Six years ago only 4 percent of the individuals seen at community mental health centers were over the age of 65 (Birren 1977). The lack of usage by the elderly cannot be laid to a single cause, especially in the case of the mental health centers where the obstacles include: lack of trained personnel on issues of aging, lack of funding to focus on specific target groups such as the aged, perceptions by the aged of the centers as places for "sick" people, transportation problems limiting their access to the centers, and problems of income where those above poverty have limited access to the services.

Realizing the need for a greater aging emphasis, the Department of Health, Education and Welfare has mandated the community mental health centers to greatly increase their service to older adults (Manpower and Training 1977). This mandate has opened up great opportunities for counseling programs in heretofore untouched clients and agencies. A comprehensive program is required if mental health centers are to respond to this community need. The thrust of this program is that of educating existing mental health center personnel around issues affecting elderly people. Before beginning such training there is the need to conduct a complete assessment of their current operation to identify possible barriers to older adult usage. The assessment should focus on: demographic survey of geographic catchment area, transportation systems, income provisions, appropriateness of clinical setting, attitudes of personnel, and types of publicity techniques utilized. Next a profile of educational needs should be drawn. At this point existing staff can be used to provide the necessary training. Arrangements can also be made, should they be required, with a local university adult counseling program or well-established community agency older adult counseling program. The training should include everything from the psychology of aging through the use of outreach techniques. Experience in Los Angeles and other localities indicates that rather than force aging training on all mental health center personnel it should concentrate on those individuals interested and concerned with the specific needs of the elderly.

Once the training has been completed, a period of time should be allotted for the combined use of trainers and trainees in serving the elderly. The trainers should be there to model, evaluate, and offer suggestions for alterations and improvements. As was discussed in the introduction to this module, universities, colleges and community colleges should not exist to provide service as an end to themselves. Through the training of mental health center staff, a community capability will be built allowing university programs to move onto other areas and other models of development.

Acute Care Facilities

In addition to entering what are commonly called long-term care facilities, many older adults enter acute facilities such as outpatient clinics, emergency rooms, and veterans hospitals. While in the case of the first two, it is unrealistic to expect a full-fledged counseling program, what can be accomplished is the training and placement of one or two individuals capable of providing service to older adults. Every out-patient clinic and emergency room has a social service worker on the staff and it is here that aging programs must be aimed. It is especially critical that outpatient programs provide this ancillary service, for the public reimbursement programs (Medicare and Medicaid) do not provide in any major way for mental health services. The emergency room capability is vital in that many aged individuals on limited income with little access to personal physician care end up at emergency rooms.

There are two ways such capability can be built into these settings. The first is through the use of field students from counseling programs. Although this is somewhat of a nontraditional field setting, there is nothing to prohibit and much to recommend such use. The process would have to be well-planned and organized so that there would be a minimum of interference with ongoing procedures, while at the same time insuring a referral system of those patients requiring counseling.

The second procedure is that of training existing personnel in techniques of serving the elderly. Given the variety of tasks assigned to such personnel, this option should be seen as secondary to the use of field work students. If chosen, however, the training should include those courses mentioned earlier such as psychology, sociology, physiology, and intervention techniques. Perhaps the most significant technique that could be taught to these personnel is that of being able to pick up mental health problems and linking the individual with the appropriate community counseling services.

The most important issue for the reader to bear in mind is that older people often present with symptoms which appear to be solely physiological, while in reality there are psychological problems or a combination of physical and mental difficulties (Birren 1977). Often older people, unsure of where the problem lies will appear at emergency rooms or out-patient clinics, thus, the establishment of a limited counseling program will meet a demonstrated need (Birren 1977).

Rap Groups (Residential Communities, Widowhood Centers)

During the late 1960s and early 1970s a variety of informal settings was established wherein counseling could take place. These have included facilities such as retirement communities or residential hotels, as well as groups organized around particular problems or clientele. In environments such as these the counselor or community college trained paraprofessional counselor can play a major role. In the majority of instances the clients attending group sessions in their residential setting or attending special interest sessions such a widowhood meetings bring with them associated problems for which they seek assistance. There are a number of ways in which counselors can be utilized.

In the residential settings a counselor can be assigned on a once-a-week basis to an activity program, health clinic, or public interest lecture series. It appears to be the most successful when it is offered as one of many services rather than selected out for special attention (Schwartz & Burnside 1974). In addition, the use of peer counselors in environments such as these enjoys great success. One point that faculty should keep in mind when contemplating the establishment of such a program is the differences in client mix. The attendees of such groups tend to be of higher income and educational level than those attending senior centers or appearing at emergency rooms (Schwartz & Burnside 1974). Not only are the problems different (more issues of marriage, leisure time), the client mix different (more men and somewhat younger), but the intervention techniques must also be different with a greater reliance on small group and private one-on-one counseling.

One of the first lessons taught to individuals running widowhood sessions is that widowhood per se is not the major problem facing the surviving spouse. Rather, it is the accompanying problems of income, career, loneliness, etc., which have to be addressed by those counselors wishing to intervene in these areas. It appears that the individual running the group should also be the counselor rather than bringing in an additional person. In this way the counseling component is open and aboveboard rather than subsumed under some other guise or auspice. The use of peer counselors is very successful in these instances, especially in widowhood groups. Once again, the differing client populations have to be taken into consideration by those conducting the counseling.

NONTRADITIONAL FACTORS

Counseling in Multiple Settings

While the term "blatant psychotic" may have some validity for the psychiatrist testifying at a court trial (though I have always wondered what a nonblatant psychotic is), it has little utility to the counseling environment. While it is vitally important that graduate students be trained in all available techniques and "schools," a vast majority of aged clients require counseling intervention, not psychiatric intervention. Indeed, as was mentioned earlier, the use of traditional clinical settings, terms and techniques tends to put off potential older clients rather than attract them. To be fair to those counselors vitally interested in older adults, it may be that the medical profession (psychiatrists), with its traditional reliance on psychoanalysis as a technique and its reluctance to serve older clients, has created this atmosphere of mistrust.

Rather than using a hard and fast rule concerning the use of any one technique, counselors should rely on a variety of appropriate approaches. Other sections of this syllabus deal in depth with counseling techniques. In order to carry on a quality and appropriate program it is necessary to be trained in numerous schools or philosophies of counseling.

The Setting: A Facilitator to Effective Counseling

Perhaps the one rule that should not be broken by those in the business of counseling older adults is that of getting out of the office and creating warm, relaxing environments conducive to personal growth. Older adults are not typical clients willing and able to drive to a private office on a weekly basis and partake of the services (Kerschner 1977). Bob Newhart's outer office may fit the needs of certain younger clients, but is seen as a barrier by most older adults. The issues and problems in this area are numerous.

The first issue involves the setting where the training takes place. If students are trained in traditional university settings with little or no placement in the community, they may then be highly reluctant to adapt to new environments in their work setting. One might suggest that clients should be encouraged to enter the university to receive the service. This suggestion, while laudatory, would fall flat in certain situations where the university is either far from the community needing the service or viewed by certain populations as less than responsive to their needs. The use of a wide variety of settings for the training of students also allows for exposure to a differentiated client mix. By placing students and staff in senior centers, nursing homes, emergency rooms, etc., we not only ensure a more responsive student, but hopefully affect the service delivery systems of the future.

The second issue involves providing an atmosphere comfortable for clients from a variety of backgrounds. It has been determined, for example at USC, that while users of legal services cross all ethnic lines the same is not true for users of counseling services (Kerschner 1977). For some groups the major barrier is geographic distance from their community; for others it is the lack of native speaking personnel; while for yet others it is the formal bureaucratic appearance of the clinic. (Nowhere was this latter point more evident than in the experience of the drug abuse free clinics which lost significant influence with the drug culture when they moved from storefront operations to publicly financed and operated clinics.)

Knowledge of how to respond to these varying needs cannot be gained from a textbook. Rather, there must be a concerted effort to reach out to and allow the community to make its needs and desires known. One of the ways to do this is to match up a peer counselor with a younger community outreach specialist. These teams can travel to churches, shopping centers, senior clubs, and other places where older people gather to "sell" the counseling message and learn the specific needs of a particular group or community.

Students have often asked why counseling programs for older people have to be so community-based. After all, they suggest, young clients requiring counseling assistance certainly leave their community. This is precisely the issue. There are significant differences in mobility patterns between young and old (Rosow 1967). Older individuals with long-time ties to their home and community, with only limited resources available to them, and with poor transportation locking them in tend to remain where they have lived and worked. Not only do they and their problems remain in the community, but the community becomes part of the problem. A variety of community-based obstacles such as ethnic pride, family matters, income, nutrition, etc., serve to make community-based services a necessity. To ignore this situation is to ignore one of the basic tenets of counseling: Begin where the client is "at." In this case the "at" is the community.

UNANTICIPATED CONSEQUENCES

Resource Scarcity

In the university and community college adult counseling programs, mobilizing personnel and resources is relatively easy. One could call on the counseling programs in the various departments and schools and on students and volunteers present within the college structure. The same is not true for programs set in the varied community settings described throughout this module. In addition to the scarcity of public or private funds, they have less access to professional consultants, students, and trained peer counselors. While they have great access to volunteer assistance, one cannot expect an ongoing program to be carried solely by volunteer help.

One of the first tasks of a college-based program desiring to reach out to the community is a comprehensive survey of agencies desiring counseling services. This survey should include personnel resources, volunteer resources, size of client population, geographic location, space for programming, and resources of client group, including income, transportation, and access to other similar services. Those agencies demonstrating greatest need combined with greatest potential for service usage should be chosen.

Differentiated Versus Undifferentiated Populations

While the serving of a varied client mix is ideal for the training of students and staff, such settings are not always possible to locate. One of the dangers in using only one set for the delivery of service is the possibility of a skewed client group. During the short period that the Andrus Center operated its program only at the university, the majority of clients were elderly Jews from West Los Angeles (Kerschner 1977). While some of the problems they brought had their parallels in other communities, certainly the experiences and attitudes were unique. If the program had not been expanded to include other sites and communities, it would have been a narrow training experience, indeed.

If one attempts, however, to serve a differentiated client mix with an unvarying staffing and program format the result can be a major failure. In addition to the use of advisory committees and outreach workers who provide community input, there is a critical need for minority students, professionals, and peers able to both speak the native language and relate easily with minority populations. The failure to move in this direction will result in a very unanticipated consequence: services will continue to be available only to those who can afford them and fit into the middle-class Anglo mold.

One Among Many

One of the spin-offs from taking a counseling service into a nontraditional setting is that it no longer stands alone as a distinct program. It is usually placed alongside other senior programs such as legal counseling, nutrition programs, exercise programs, etc. While this may create some problems of space, personnel use, and resource sharing, there are some clear benefits also.

The degree and ease of referral is extremely high when multiple services are available in the same location. Many times someone will enter with a verbalized legal problem when in reality the issue is one better handled by a counselor. The reverse is also true, for many times a client will arrive very upset and ask for counseling, when the basic issue is in reality a legal one that can be handled by trained attorneys, skilled in problems of law and aging. In order for such interaction to work, there must be clear understanding of each other's programs and a willingness to refer clients secure in the knowledge that the other service is of high quality.

Intervention Versus Service on Demand

Perhaps one of the most difficult issues facing a counseling program is deciding when to intervene and when to wait for the client to ask for the service. While counseling personnel are steeped in a tradition which states that the privacy of the client must be maintained, such a posture can also result in client neglect.

In an effort to walk that thin line between interference and professional responsibility, counseling programs must develop close linkages with community service agencies. These agencies (departments of social service, public guardians offices, hospitals, and nursing homes, among others) can provide the necessary client profile to help determine the most appropriate course of action.

While we must continue to lean in the direction of client privacy and confidentiality, we cannot abdicate our professional training when the situation clearly requires speedy, yet appropriate intervention.

Implications for Counselors

Those engaged in older adult counseling are more than one-to-one counselors. Counselors have a role, and, indeed, a responsibility to actively seek the improvement of the total environment of older adults seeking their assistance. Although this seems to require counselors to be renaissance persons, the result can be accomplished through close ties with the many programs and services offered to the older adult. In fact, counselors can play the role of information, referral, and tracking specialists. By taking a holistic view of both client and his mental health, counselors automatically come in contact with other elements of the client's "world."

In order for such environmental improvements to take place, training programs for counselors must include an in depth study of public and private aging services including such programs as: Title VII, nutrition; food stamps; Supplemental Security Income; Medicare and Medicaid; and home health care, nursing homes, and social services.

It is not suggested that the counselor must speak several languages, be trained in all counseling techniques, be knowledgeable concerning all community agencies, and be willing to travel hundreds of miles a week to deliver his/her service. It is hoped instead that counselors will become aware of the need for such services and will be willing and able to make appropriate linkages and referrals. The counselor's ability to channel the client's problems to the proper service for amelioration will tell as much about his/her success as will the resolution of a specific mental health problem on a one-to-one basis.

Individual/Class Activities

Since this module has focused on the nontraditional environment, the classroom activities will seek to prepare students for these settings by making them more familiar with the diversity of service environments available to older adults within their own communities.

In groups of 3-5, students should visit both a four-year university and a junior college within their community. Several hours should be spent at the counseling center of each site observing the clientele and counselors and noting the types of services being offered. Any literature about the sites should be collected. Appointments should be made in advance of the visit to allow brief interviews with staff regarding the nature of commonly reported problems and needs of the clientele (without of course, violating any codes of confidentiality).

Students will be asked to discuss and consider, within their groups of 3-5, some of the following:

1. Is the service provided ancillary to training and research?
2. Are there community agencies that offer these same services? Are these services duplicative or do they serve an explicit purpose with a defined student population?
3. How do the two sites (a four-year college and a junior college) differ in clientele, problems reported, accessibility, staffing patterns, impact on the community, etc.?
4. Are these programs perceived to be ones that can be picked up by the appropriate community agencies in the future?

Each group should prepare a 2-4 page brief highlighting similarities and differences in these programs. One person from each group should be selected to report the group's findings to the class. Each student should then give his/her personal summation to the class, briefly relating which program they felt better met the needs of its clientele.

Enlisting the cooperation of a community mental health center, a senior center, an adult day care program, etc., students are asked to develop and administer a needs assessment for the site of their choice. The class should first collectively discuss the procedure to be used in performing a needs assessment in a site where counseling services are already being provided to older adults (with appropriate caution not to promise the implementation of services which are reported to be absent but desired). In small groups the students should develop the assessment instrument, administer it, and report their findings to the class. A statement should be made in reporting what kinds of services could be implemented to better meet the needs of the older population served.

Students should work in groups of 3-5 to develop a media presentation which advertises counseling services for older adults as part of a community service offered through an agency. Students may chose whether to devise a presentation for TV, radio, etc. Students will then present to the class their "announcement," "advertisement," or "promotional material" prepared. The class will be asked to evaluate whether these media presentations would attract older persons to the counseling services being promoted.

Students should critically review the staffing patterns of a multipurpose senior center. Recognizing the goals of the center, its budget, and the needs of the population it serves, students will be asked to do a paper exercise to "fill the void." Assuming that volunteers could be used and are available, conceive a program that would most comprehensively meet the mental health needs of the population served. If volunteers could be utilized in new staff positions, describe their roles and requisite background.

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Evaluation and Assessment

1. Describe what you perceive as the major reason that older people have remained outside of the counseling environment. How can the counselor remedy this situation?

2. Discuss the strengths and limitations of a university-based counseling center for older adults. What are some factors a counselor should know about the community at large before beginning a counseling service through the university setting?

3. In establishing a community-based counseling center what are some of the variables which should be taken into consideration to minimize barriers to accessibility?

4. It is postulated that the counselor has a "responsibility" to older persons to actively seek improvement of their total environment. Suggest some ways in which counselors can help bring about improvements in programs and services offered for older adults in their own locales.

5. Discuss the similarities and differences of counselor roles and functions among the various settings described in this module.

MODULE X

PRACTICA AND INTERNSHIPS FOR STUDENT-COUNSELORS OF THE AGING

Charles J. Fogelman

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Illustrative examples, case studies, and editorial assistance to the author were provided by W. Sherod Williams. He is currently working for the Adult Development and Aging Program at Antioch University as an Assistant Professor and practicum director for the program's counseling track. Additionally, he has served as a consultant to the Harford County Community College and the George Washington University gerontology programs. He has counseled elderly adults in both in-patient settings and out-patient settings. His current research activities involve the examination of factors related to the attitudes of those who provide care for the elderly in institutions.

The author wishes to express his deepest appreciation to his assistants, Sue Immerman and Judy Siegel.

PRACTICA AND INTERNSHIPS FOR STUDENT COUNSELORS OF THE AGED

Rationale and Objectives

Why, it may be asked, is this module different from most other modules? Why is this one organized differently? Why is it less didactic? Why does it leave more loose ends and more to the initiative, interpretation, and imagination of the reader? The answers lie in two areas: the distinction between the classroom and the live setting and the amount of material and experiences already available, or absent, about the topic at hand.

The other modules in this syllabus, with the occasional exception of Module VII, deal with the substantive information a student ought to have as part of his or her preparation to be a counselor of older persons. This module is concerned with the application of that knowledge and its integration into the knowledge and experience of a whole counselor, not with the information for its own sake.

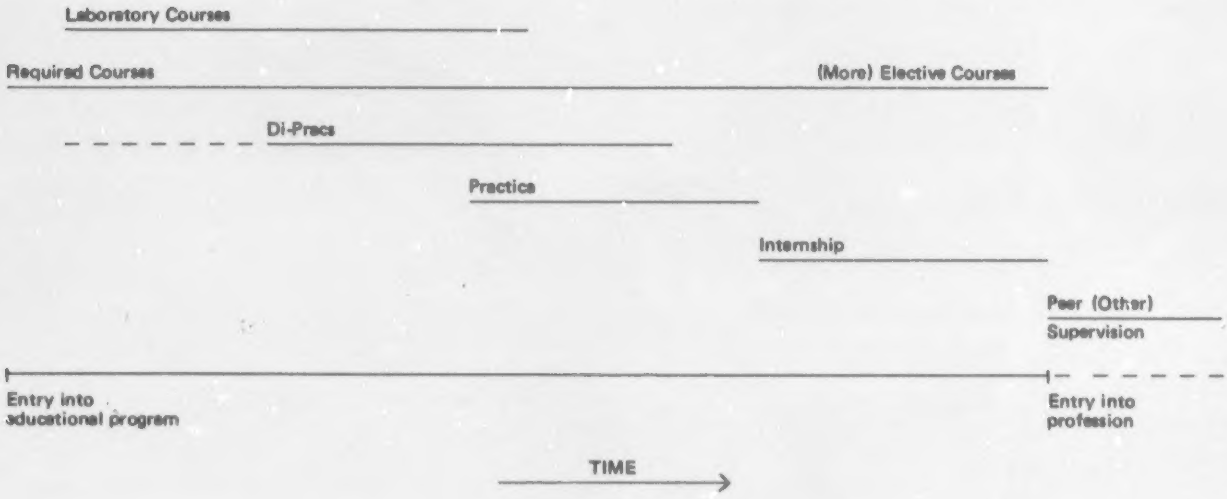
A recurring theme throughout the whole module is that of the increasing responsibility and skill on the part of the person who is becoming a counselor: Classroom knowledge is the base and supervised experience the mechanism for growth from student to student-counselor to counselor. Thus, a student may read codes of ethics as part of classroom assignments or in preparation for supervised experience but it is in the application of that knowledge that the apprentice learns professional behavior. It is with that application that this module is primarily concerned.

The module is also concerned with the supervised experiences that students who intend to counsel older adults might have. One would therefore review the literature on supervision, practicum, internship, counseling, and aging in order to gain information and would consult those schools at which the training of gerocounselors took place. But there is not much literature (see related resources) about supervising gerocounselors (though there is a burgeoning literature in supervision generally) and but a handful of schools at which anything resembling gerocounselor training takes place. Thus, much of the material in this section may be seen to represent a novel integration of material from a variety of sources, including in large measure the author's own experience, while many of the other modules have a more extensive base.

This module has as a premise that students of gerocounseling[1] progress along a continuum of increasing knowledge and practice. A base of substantive knowledge gained in the classroom is supplemented by, and built on, a series of supervised experiences, each representing increasing skill and professionalism. Numerous terms for such experiences have been used by counseling profes-

FIGURE 1

Time Line Model of Counselor Training Indicating Occurrence of Supervised Experiences



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[1] "Gerocounseling" is the only term coined for this module and follows the increasing use of the term "geropsychology" elsewhere. Synonymous terms used are "counseling older persons," "geriatric counseling," "establishing a helping relationship with older adults," among others.

sionals (i.e., counselors, psychologists, social workers), including "di-prac," "externship," "practicuml" "internship," "preceptorship," "field experience," and "residency." Definitions, however, have not been standardized. Therefore the author has chosen the use of the terms "practicum" or "internship" to reflect the increasingly more sophisticated practical training experiences of the gerocounseling student.

First, a student may be enrolled in laboratory, or "di-prac" (combining didactic content and carefully constructed and strictly supervised live experience), then moves on to practicum training (the early parts of which generally consist of exposure to the range of a counselor's activities in a given setting, the later parts of which consist of getting specific work experience), and finally has the internship experience(s), essentially an apprenticeship in which a student performs under supervision the whole range of a gerocounselor's functions in an integrated fashion. Figure 1 schematically describes this continuum model of training.

The objectives of this module are:

(1) To provide exposure to the issues involved in designing and implementing supervised experiences for gerocounselors in training.

(2) To provide a framework, through the use of examples and the identification of questions to ask, for incorporating supervised experiences with older persons into the programs of students who might become full-time gerocounselors or who might have just incidental professional contact with older persons.

(3) To provide a step-by-step outline of what might go into the construction of a series of supervised experiences for students of gerocounseling.

(4) To suggest differentiations, or ways to differentiate, between practicum-level and internship-level experiences for gerocounseling students.

(5) To provide some discussion of the various roles and setting in which a gerocounseling student might be placed and their advantages and disadvantages, especially in regard to supervision.

(6) To provide some specific examples of practicum programs, issues, and development procedures so that the counselor educator can consider how the theoretical discussion in this module might be applied. The examples are not meant to preclude the use of other solutions to practicum development problems but are intended to illustrate the implementation of sound experiential training in the area of gerocounseling.

Content

Why should there be supervised practica and internships for student gerocounselors? It is clear from general academic practice, from the statements of professional organizations such as APGA, APA, and NASW, from the literature, from experience, and from common sense that supervised training experiences for students are a fixture in the professional landscape. Many learned discussions on the topic are available (see related resources). Several reasons are particularly important, however, and these will be briefly reviewed here.

First, the ethics, practices, and goals of the teaching professional both as a teacher and as a professional figure heavily in understanding the need for supervised training. Those established in a field, especially an interventive field like counseling, must assure the quality of a profession, ensure its standards and reasonable practices, convey its ethics, and prepare and endorse its newest members. A teaching professional declares a student ready to take on increasing responsibility for others; this can only take place justifiably if a teacher (or, by extension, a school) has had regular and intense contact with, and thus knowledge of, a student as his or her skills were developing.

Second, this practical training time can be most valuable because it represents a career period in which it is more permissible to make errors, since they can be corrected, and useful patterns can be set. This is a time when a student can learn that it is not possible to know it all, that everyone needs other opinions and perspectives. Errors and misjudgments can be corrected or forestalled by a good supervisor, thereby serving current professional needs, and a responsible pattern can be started by the student, benefiting the future.

Finally, this is also, it is important to note, a period in which quality control can and must be exercised. Not only must students be developed into good counselors, but those who are simply not destined to be effective professionals must be counseled out of the field, perhaps the consummate test of the skills of the teaching counselor. Client and professional interests are not well served by endorsing the entry into the profession of those who should be doing something else (or finding a different specialty within counseling). We must have the sense and courage to direct people out of as well as bring them into the profession.

These three reasons can be considered in regard to gerocounselor training. As noted in other modules and as is evident by the existence of this whole syllabus, in recent years the demand for gerocounselors has been increasing. We must be careful, first, not to recruit students who have not received adequate training, second, not to give less than competent trainees professional standing just because there may be a personnel shortage, and, third, to make certain that supervisors skilled in working with older people even if they are not or are not yet counselor educators, are available to all students.

Further, we should consider that this portion of training can provide students with a basis on which to choose from a variety of gerocounseling subspecialties, especially if they are ill suited for a particular one. As an example, someone who simply cannot work effectively in a long-term care setting might make a superb preretirement counselor or an excellent community mental health center outreach to the elderly worker.

Is there anything special about practica and internships in gerocounseling? Yes and no. As the reader has no doubt been able to discern from these modules, there are things that distinguish adult development and aging from other counseling areas.[2] Human concerns and the range of skills a counselor needs are no different for older people than for younger. Older humans grow and change, have a full complement of emotions, and look for meaning and love just as younger people do; perhaps what a gerocounselor in training needs to know is just that.

Some aspects of working with older people, however, are different from working with younger individuals. Working with older people requires a slightly different perspective, which can have an effect on the training of students. First, a student gerocounselor must understand that there is no way that he or she can pretend to understand a much older person by virtue of shared experience — the older person has done, seen, and lived through more. Second, older people were born in a different time and have had an entirely different set of experiences than their juniors (the cohort effect); this means that a gerocounselor must make a special effort to understand an older client's frame of reference. Third, an older person's world may be much smaller and more restricted than when he or she was younger or than that of younger people. Finally, there are often expectable physiological, and to some extent mental, changes that might occur with aging. These and other related themes are developed in other modules. Although the discussion of these differences presupposes that the counseling student is young, this is not to negate the fact that older people may be counseling students themselves. Refer to module VIII for information on peer counseling.

The "yes" and "no" answer above also applies to the settings in which a student might get supervised training. Historically, the majority of counselors have been trained with the goal of being helpers of students and career-seekers; so most training sites were likely to have been schools or counseling centers. With more and more counselors moving into other areas of concern, such as problems of daily living, the kinds and numbers of training sites have increased as well. Thus, a graduate student in counseling today might expect to see clients in a drop-in center, a community mental health center, or a penal institution, as well as in the traditional settings. There is not much difference in these kinds of settings, where one might work with older people occasionally. But when we consider such placement sites as nursing homes or other long-term care facilities, senior centers, congregate nutrition sites, and others in which the population is entirely or primarily older, differences do exist.

These differences in sites where a student might receive supervised training in gerocounseling and where a gerocounselor might find full- or part-time employment raise some difficulties, as well as present some advantages. The most important difficulties inherent in using any kind of counseling program sites are: starting a working academic/service relationship, finding tasks and roles appropriate to a student's level of development (the tendency is either to use students as volunteers or as "go-fers," instead of expecting them to be professionals at the start and allowing them to progress sensibly), and finding an appropriate field supervisor who can ensure sensitivity to the student's academic needs.

The advantages in using a new program site include the opportunity for students to shape their own novel experiences, the likelihood that both full-time aspiring gerocounselors and those who might only see older adults incidentally would be able to find meaningful and complementary training, and the chance to set up later employment in a similar type of agency. Module IX presents an excellent, detailed description of some settings in which a gerocounseling student might be placed.

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[2] "Adult development and aging" is used here in preference to "gerontology" because it reflects the author's bias that human development occurs throughout life and that the last part of life can only be understood in the context of a whole life span. Further, this designation is gaining some currency in the field, as is "life-span developmental psychology."

How many practica or internships should a student do in the same setting? Inherent in this question are several salient professional and ethical issues whose resolution may affect the student, the client, the site staff, and the training program. Although this is not a new question in counselor training, the factors to consider in making sound judgments and decisions may be very different when working with an older population. Furthermore, sensitive attention to the duration (and termination) of a supervised experience is most important in situations where the clients are terminally ill.

What should a student know, be applying, and be learning under supervision? It is fundamental to the continuum model of increasing skill and responsibility that a student start with a knowledge base, modify and add to that base while applying it in a practice situation under supervision, and be engaged in new learning while in supervised training. The most important aspects of supervised training, then, are integration and growth. This section describes what students at the practicum and the internship levels might know before starting, what they might be applying, and what they might be learning. Since much of the academic substance of these topics is covered in detail in other modules, most will only be noted here.

What should a student know before starting? There is some debate about when a student's course of study s/he should begin experiences with real clients and some variance in timing among academic institutions. It is assumed here that by the time a student enters a practicum s/he has some knowledge of the basics of counseling skills and concepts. A student in gerocounseling, however, might not yet have begun to take specialized courses in adult development and aging. It is recommended that unless a student is enrolled in a program exclusively devoted to gerocounseling, s/he should have at least two practica, one dealing with being a counselor in general and the second with getting exposure to working with older people. A full-time gerocounselor aspirant would have no reason not to combine these experiences. The outline presented here does combine them.

PRACTICUM STUDENTS

1. General areas

Related to counseling: A student ought to know the nature of the field, be familiar with a number of models of intervention and service delivery, have a beginning understanding of empathy and communication, recognize the importance of clear values, and be familiar with the professional responsibilities of counselors and counselors in training, since s/he will be operating as a professional at some level.

Related to adult development and aging: A student ought to be familiar with the contents of the other modules in this syllabus, which together provide a more than adequate beginning knowledge base. Particularly important are normal, or expectable, age-related changes, acquaintance with the range of service and support systems available, myths and facts about aging (especially about older people's capacity to grow), and ability to recognize and act on crisis warning signs by referring clients to the appropriate agency.

2. Issues specific to an individual gerocounseling practicum

There are a number of things that a practicum student, particularly a beginning practicum student, ought to know before embarking. First, he or she should be aware of the nature of the host agency and of human service delivery agencies in general. This includes considerations of the agency's philosophy, finances, organization (structure and the trainee's place in it), client relations, interaction with other public and private agencies, and staff characteristics (i.e., occupation, training, theoretical orientation).

In particular, a student must understand where older people fit into the agency's structure, whether this is voluntary or by government or economic necessity, and what the agency's history and future plans are in regard to older people. The key question to be asked here is, "Should, and do, older adults matter to this agency?" Should an agency that serves various age groups, including older adults, be selected as a practicum experience for a gerocounseling student? These agencies may focus on the concerns, needs, and desires of an elderly population to varying degrees.

For example, in a community-based crisis center, a student was placed in a practicum with the goal of developing outreach services for older adults. The crisis center had served only a small number of older adults. The center apparently saw the placement of the student not so much as an opportunity to serve older adults, but as an opportunity to increase the total number of clients served. As a result of the difficulties inherent in implementing outreach services and the additional commitment of staff needed to provide the services, the student gradually returned to serving the predominantly younger population typically served by the crisis center.

The student was encouraged to examine this situation and to consider how a similar problem might occur in other agencies that did not primarily serve the older adult. In order for this particular student to acquire actual training and experience in working with the older adult, he had to be transferred to another site. Clearly, other solutions to this type of problem are possible. For instance, the faculty supervisor could intervene to direct the practicum experience as originally proposed, which might not only enhance the student's practicum experience, but also have the positive long-term effect of continuing increased services for the elderly beyond the duration of the practicum.

Second, the practicum student should have a sense of what the administration of human service delivery programs is about. No student, or professional, can be wholly effective without this knowledge; rarely if ever does a counselor have the luxury (the poverty?) of operating in a vacuum. The question for the gerocounselor educator and gerocounseling student to ask here is, "Is it possible to provide meaningful service to older persons and to learn to be an effective gerocounselor in an agency administered in this manner?"

Third, the student should be aware of the nature of the relationship between the trainee and supervisor(s). Especially for a new trainee, questions of primary loyalty (to the clientele of course, but to which supervisor?), independehce, and the acceptability of making mistakes exist. The key gerocounseling question here is, "Will the supervisor be able to provide the time, competence, and guidance (based on his/her own continuing experience with older persons as well as with the trainee) to make the experience meaningful?"

These, and other, issues, may be seen to be relevant to anyone under supervision. They are seen here, however, as particularly critical for persons taking the first steps.

INTERNSHIP STUDENTS

In general, it can be said that before a student progresses from practicum to internship s/he must have a command of those things with which practicum stndents only need acquaintance, as mentioned in the preceding outline. It might also be said that a student is eligible to move on if s/he is aware of what s/he doesn't command and knows enough to admit it and learn and be supervised in these areas.

There are, of course, additional categories of knowledge with which the intern should be familiar and they are outlined below. It is assumed that an internship for an apprentice gerocounselor will be in a setting that provides substantial services to older people and their families.

1. General areas

Related to counseling: The main piece of knowledge beyond that useful to practicum students is in the area of ethical practice. A fuller discussion appears in the next section of the module, but it is important to point out here that interns, as relatively independent and whole professionals for the first time, must be familiar with relevant ethical codes, committed to learning and to demonstrating responsible behavior, and sufficiently sensitive to potential ethical dilemmas to discuss them in supervision. This is not to say that practicum students should be ignorant of ethics, but rather that internships are where they are first experienced.

Related to adult development and aging: the major content areas that a gerocounseling intern ought to master and begin to use at this state include a knowledge of the patterns of deviance more prevalent in older populations and their warning signs, special modes of intervention that might be appropriate to an older clientele, the techniques of life review, and the necesary connection between physician and gerocounselor.

2. Issues specific to an individual internship

The areas of concern here should reflect the intern's own developing special interests and the special needs of the population being served. Possible areas in which a student might specialize or concentrate include counseling older women, special populations (e.g., aged ethnic minorities, sexual minorities, institutionalized or incarcerated populations, (the handicapped, or the mentally retarded), death and grief counseling, sex and marriage counseling for older couples or older singles, late and postcareer planning, career change or second career counseling, and mid-life crisis.

What roles might a gerocounselor trainee fill and what levels of responsibility? As the trainee progresses along the continuum from novice to apprentice to new professional, there are various roles that might be assumed in a variety of settings. These can be seen to reflect the range of foles and settings eventually available to a working counselor; they can also be seen as additive, a series of limited experiences adding to a whole. This section of the module presents a dicsussion of the kinds of roles a gerocounselor in training might fill and how these might reflect varying levels of responsibility. Since possible settings are discussed in Module IX and elsewhere in this module, settings are included here only as they are relevant.

ETHICS, SKILLS AND BEING A MENSCH

Leo Rosten, in The Joys of Yiddish (1968), defines a mensch as an upright, honorable, decent person, someone to admire and emulate. A gerocounselor, or a trainee, or one who is both, aspires professionally to these ideals. The substance of translating these ideals to counseling can be bound in professional codes of ethics and the behavior (good and bad) of already established counselors; the manner of the translation is in the models of others and in the supervisory relationship. As a student progresses from a cautious and frightened first interview with a client in practicum to taking clients from initial referral all the way to completed counseling to helping to supervise others, s/he should learn what the majority of the profession, speaking through its associations, endorses as appropriate or right behavior. This includes learning what is appropriate to a given setting as well as to the profession at large. Most important is that just as a student develops an individual style and philosophy of counseling based on all his/her experience and knowledge, s/he also develops an individually appropriate ethic, which though based on professional codes is not necessarily identical to them. It is important to distinguish between responsibility, which is the abstraction referring to decent behavior, and accountability, which means standing up for what you do.

Moving Through Roles

The student is constantly adding to a repertoire of skills, often reflected in the roles taken in training settings. A beginning diprac student has only a particular task or skill to consider and gets regular and intense feedback and evaluation from a supervisor about that task or skill; this involves a fairly low level of individual responsibility, a greater level of responsibility toward a client, and considerable accountability to the school. A beginning practicum student may do more observing and inquiring than intervening and thus is primarily responsible to him/herself for learning, and to all for behaving reasonably.

A higher-level practicum student is beginning to apply knowledge and use skills with clients, who, despite their knowledge that a trainee is seeing them, have a right to expect quality service from the agency; this involves greater responsibilities in terms of the kinds and extent of services provided and greater responsibility in terms of meeting everyone's expectations for a counselor in training. The higher level practicum also involves a greater level of monitoring by, and thus responsibility to and of, supervisors in their roles of representatives of the profession, of the agency, and of the training institutions. At the internship level, which involves being a wholly functioning, if apprentice, professional counselor, the range of responsibilities and of responsibility is greatest for the trainee, least for the school supervisor, and fairly high for the on-site supervisor.

For example, a student had spent time in two different practicum sites fulfilling the beginning and advanced level practicum requirement for the school. Near the completion of her degree, she inquired and arranged for an internship in gerocounseling at an institution nearly 500 miles away. Some significant differences between the practicum experience and the internship experience included the following:

1. The practicum experience only required 12 hours a week versus 40 a week for the internship,
2. The internship experience was highly specialized and focused on working with dying patients in a hospice setting essentially as a full-time staff person.
3. The practicum was unpaid while the internship experience paid a stipend to the student.
4. The internship selection process was highly competitive, requiring the student to develop skills before entering the internship. This is very similar to what one does when applying for a job in gerocounseling,
5. Because of the distance and nature of the internship experience, the at-school practicum director had very little responsibility for any ongoing supervision, while the supervisor saw the practicum student once a week throughout the practicum.

Kinds of Roles

The preceding discussion dealt abstractly with degrees of responsibility and levels of tasks or roles a gerocounselor trainee might fill. Following are examples, by level, of what these might mean in practice.

Beginning Practicum Level

At this level a student is primarily observing and assisting. For many this might be a first chance to interact with an older person on a regular basis. A practicum trainee at a site primarily serving older people (nursing home, senior center, nutrition site) would do well to begin to develop communication skills with older people and to discuss the realities of aging with practicum colleagues and supervisors. A trainee at a site that serves older adults only incidentally (community mental health center, hospital, community crisis center) might try to understand the role its services to older people play. For example, a state hospital provided an opportunity to interview older adults and was chosen as a site. In this case the practicum site was linked with a course in interviewing the older adult. An arrangement was made for students to do intake interviews under the supervision of a psychiatrist and the social worker at the state hospital. Other sites were identified so that students could experience interviewing older adults in noninstitutional settings. Similar arrangements were made with, for example, a community mental health center in which students were given the opportunity to do intake interviews with older adults who were not institutionalized.

For these practica, the goal was to provide students with an opportunity to gain experience interviewing older adults. The experience was limited to engaging only in interviewing and gaining experience and skills in it. The instructor for the course attended these sessions and gave feedback to the students about their performance. In addition, tapes were obtained and discussed with the students in small groups (two or three to a group). Each of the interview opportunities was preceded by a lecture in class concerning issues or skills needed for interviewing older adults in the two settings.

Advanced Practicum Level

At this level a student is beginning to act independently, to take some initiative, and to work directly with clients on a continuing basis. A trainee might engage in outreach activities such as making home visits and evaluations, on-site interviews of older people, sharing group counseling with more practiced colleagues, and leadnig task-oriented groups. If the trainee is interested, s/he might engage in research or program evaluation, consult within the agency on issues involving older people, educate or share supervision of less experienced trainees, and establish individual counseling relationships with a limited number of older people around very specific tasks such as late-career and postcareer planning or, for particularly skilled and sensitive students, death and bereavement or loss in general. By the time a student completes the practicum s/he should have had the experience of visiting older people in all the sites in which they live, including their homes, and ideally should have had the opportunity to interact with older people at all levels of health and functioning. Although a trainee should not be expected to have intervened in all these situations, some exposure to the whole range should have occurred.

Internship Level

At this level a student is devoting full time to the integration and application of what has gone before and is functioning for all intents and purposes as a professional, except that s/he hasn't a license or certificate and is still sheltered under a supervisory wing, responsible to the parent academic setting. A student should have the opportunity to pick an area or two of great interest (individual in-home counseling, retirement counseling, counseling children of older parents) and to do everything just as though s/he were employed or independently practicing as a professional gerocounselor. A student should, however, retain the option of continuing a variety of tasks at greater depth than in the practicum. An apprentice gerocounselor could legitimately take part in the following activities, among others: program development and grant-writing, management of individual clients or groups, joint supervision with other supervisors of less skilled students, consultation to other related agencies, shared instruction including inservice training, administration or assistance in administration, and referral of clients to other counselors or other agencies with client-appropriate skills beyond their own (a must).

The Advocate's Role

By the time a student reaches the internship level, some experience with or exposure to various kinds of advocacy should have occurred. A graduating gerocounselor ought to have a clear idea of where s/he stands about advocacy, since it is one of today's major ethical professional issues. (See Module XI.) Political advocacy means concerted action outside the office (not individual membership in such organizations as the Grey Panthers, which should be expected). It is essential that any student involved in political advocacy be truly competent in and knowledgeable about legislative issues and policy. It is the author's opinion that any mature student is irresponsible if s/he does not act as a political or legal advocate for an older person or group of older people who are being consistently shortchanged.

Professional advocacy is appropriate to the level of skill and sensitivity agreed to by student and supervisor. The student might take the lead, for example, in presenting an older person's case to an agency used to giving only brief notice to the concerns of older people (this may be a case presentation in the medical sense or a plea for service and support — sadly, an often-necessary activity for helpers of older people and their families). Or a trainee might orchestrate the necessary range of services for an older person and educate the providers to the special needs of the client and the general client group (being careful not to step on social workers' toes). In either case, the student is acting out the professional responsibility to see that his/her clients are effectively served.

ESTABLISHING A SUPERVISED EXPERIENCE

This section deals with the nuts and bolts of arranging practica and internships in gerocounseling, including identification and discussion of issues involved and step-by-step suggestions for implementation. Since this is a hands-on section, the material is primarily presented in schematic form, allowing for the clearest identification of critical points and for the greatest ease of application to individual educational settings.

In order to set realistic and measurable goals for the student, the school, the site, and the profession, it is strongly suggested that an individual contract be executed between the student, the school, and each field site. At the very least, a contract can serve as a guide for counselor educators as they move into the new and uncharted area of gerocounselor training. At best it serves as an effective plan of personal and professional growth and development for the student. Contracts, of course, will vary with the goals of the institution, the student's academic institution, and the host agency providing the practicum experience for the student. A contract is useful so that the continuum of training can occur, so that there can be shared understandings and expectations, and so that evaluation can be made by assessing progress toward reasonably clear goals.

What needs to be considered in developing a contract? A supervised experience represents new learning, either in application or in integration. The contract should identify, as clearly as possible, the new learning that is to take place, and the mechanisms or modes by which this learning will occur.

- Does the contract clearly specify that the student will work at a level appropriate to his/her skills and will be provided with opportunities to change as and when necessary and reasonable?
- Does the contract clearly specify the extent and type of supervision to be provided in the field and at school and by whom?
- Does the contract describe what tasks the student will engage in and what new learning is expected to occur?
- Is the contract general enough not to be restrictive and specific enough to provide guidance and limits?
- Are the amounts of time on site and with each supervisor spelled out?
- Are evaluative criteria and techniques defined? Are the competence demonstrations that enable a student to move to the next level of professional responsibility clearly specified?
- Will sufficient exposure to or involvement with older people and their concerns take place? Overall, does the contract reflect fairly and adequately the goals and needs of the host site, the school, and a student at this level? Can the contract fit into a series of contracts reflecting the student's progress?
- Are the responsible and accountable persons named and has professional insurance coverage been arranged? (Ordinarily, students are not wholly liable for their actions and thus are not eligible for malpractice insurance; they are usually covered by the school's or agency's policy. This is necessary not only in the unlikely event of litigation, but for simple communication purposes as well.)

For example, occasionally a site requires that the student be covered by malpractice insurance. This is often the case in a medical or a medically oriented setting; however, some attention needs to be given to malpractice insurance at all sites. In one case where a student was working at a community mental health center housed in a county hospital, arrangements were made for the student to take out student malpractice insurance through the American Personnel and Guidance Association at a very reasonable yearly fee. This highlighted the professional nature of the student's activities. In the view of the site institution, the student's activities made him/her vulnerable to the same professional requirements and risks that a trained professional gerocounselor experiences in his/her work. In any case, it is recommended that students be advised of their responsibility in the area of providing professional, competent, and ethical services while working as a gerocounselor trainee.

The burden for seeing the contract, and indeed the whole supervised experience, through should fall primarily on the student, with the active advice of a faculty advisor or supervisor. An intern, presumably, would be able to accomplish much on his/her own initiative. An intern should, in order:

- Formulate general goals in conjunction with an advisor.
- Participate in the identification of a useful potential site or two.

- Discuss with a representative of the potential site(s) and his/her advisor the "goodness of fit" among his/her goals, the school's needs, and the site's needs and resources.
- Identify appropriate supervisor(s) at school and on site and enter into supervision agreements with them with the guidance of the practicum coordinator at the parent school.

A contract draft should then be submitted to the site and the school and discussed. After joint consultation, a final contract should be drawn and signed by all three parties and entered into a student's record.

Site selection for the different steps along the training continuum should reflect the trainee's increasing levels of experience, responsibility, and his/her needs. An initial practicum need only provide general supervision, an appropriate population of older people, and access to this population. A later site should make available more intensive supervision, clients to work with, and a range of specific experiences. An internship site must offer a continuing source of clients, a defined variety of experiences and tasks, a professional title and office, regular supervision, and the respect due a new colleague. An early practicum might even be run directly from school, but an internship must generally be physically and organizationally removed from, or only indirectly related to, the school.

Some further examples might be useful here. At the beginning level we might look to any place at which a number of older people might be found, including rap groups, congregate nutrition or housing sites, and senior centers, where a trainee might get a feel for interacting with older people. Later it might be appropriate for a student to take on a special set of responsibilities at these sites, such as leading a group, or to work as a generalist, at a different kind of site, such as a nursing home or community mental health center.

Once again the role of services to older people in the host agency is a very critical issue and it is important for the supervisor as well as the student to make a quick diagnosis of what that role is.

For example, two students were placed in two different community mental health centers, both in suburban areas of Washington, D.C. At one community mental health center there was a half-time social worker as well as five or six students in training who helped provide gerocounseling services to older adults. In the second center there was a nurse-practitioner who, in addition to her other duties, was attempting to develop a pioneer program for gerocounseling services for older adults. An agreement that in the upcoming year some money would be allocated for geriatric mental health services at the center had been reached.

The first community center's program represented a substantial commitment, not only in terms of actually having a paid professional whose primary duty was as a gerocounselor but in training a number of gerocounseling students.

The second community mental health center was in the initial states of developing gerocounseling services. The role of the services and a commitment to services for the older adult had not been clearly established. The second center represented a situation in which there was a high risk that the goals of the students — training and obtaining experience in gerocounseling — might not be met since a commitment to these services had not been established. In this case some serious thought needed to be given to whether the individual student placed there would in fact have been able to obtain the desired experience.

Supervision

The nature of supervision is much debated among professionals and educators. Some say it is purely teaching; others say it is modeling; still others say that counseling supervision is nothing so much as specialized counseling in itself. Of course, many combine these positions. The position taken here is that supervision can come in a variety of forms, many of which are discussed here, and that the essence of supervision is the relationship between the supervisor and the trainee. In this relationship, burdens are shared, respect is mutual, the student gradually takes over responsibility for his/her growth, and all manner of issues are explored. The faculty supervisor, acting with the guidance and support of the field supervisor, retains authority over whether or not the student continues along the path of becoming a professional gerocounselor.

Because gerocounselor training is a relatively new area and because many field sites therefore will be nontraditional, an odd sort of conflict aries. On the one hand, the novelty of gerocounseling, together with the weight of serving a new population, makes one think that greater reliance should be placed on the field supervisor, who may be chosen because of his/her experience with older people and, perhaps, in supervision generally rather than for credentials, as is usually the case with counselor educators. On the other hand, counselor educators want to learn more about this new field and rightly do not want to hand their carefully nurtured students over to a different kind of professional. Over time, of course, this conflict will lessen and disappear, but currently it is very much with us.

Aside from having faith in the integrity and reputation of the site and supervisor for professional reasons, the best course of action until mutually acceptable working relationships can be established between sites and schools on an ongoing basis is to maintain greater communication between the field supervisor and the school-based supervisor than might be found in more traditional counseling practica and internships. Related to this is the issue of evaluating supervisors and supervision. Evaluation is important on a continuing basis so that poor supervisors and poor sites can be weeded out before they cause too much damage or become too ingrown.

Who supervises? A better question is, "Who is responsible for supervision?" A supervisor does not always take the directing role in supervision. For example, at the site, the supervisor may be a person with counseling experience, preferably with training and supervisory experience; a person who is accessible to the student; a person who sees, or can see, the same client or range of clients or who engages in the same activities as the student; or a person who has completed at least the same level of training as the student (or, alternately, a person without similar education but with extensive experience). At the school, the supervisor might be a faculty member, perhaps the student's own advisor or one person who is responsible for supervising many students. Supervision may also be shared among teaching and nonteaching faculty or with qualified advanced graduate students; some supervision, under general faculty guidance, can be done among peers.

What goes on in supervision? Supervision essentially consists of a more experienced counselor helping the trainee to understand the dimensions and implications of the experiences that occur regarding a site. The trainee may have questions on case material, critiquing students' counseling tapes, ethical quandaries, procedural questions, and may or may not include the discovery of material not previously presented.

In accordance with the contract, a beginning practicum student on site should expect questions to be answered and should expect that a range of activities to familiarize him/her with the host agency's activities either exist of can be rapidly constructed. The on-site supervisor has the responsibility of orienting the student and of being responsive to the trainee's questions about the agency, its operation, and (selectively) its clients.

An advanced practicum student can expect that an on-site supervisor will schedule regular time with him/her during which both general and specific case material will be discussed. Both supervisor and student (if a group, all participants) are likely to have points to present; each sees from a different perspective after all. It is the particular responsibility of the supervisor to tell the student how s/he is viewed by agency clients and staff alike.

An intern can expect to participate in the same professional reviews as other professionals at the site do, in addition to the same group supervision experiences that other interns have. Further, s/he can expect regular and intense conversations with his/her supervisors. These discussions will cover not only job-related material (counseling techniques, diagnostic assessment, etc.), but will probably include issues dealing with how to find a regular job after graduation.

At school a beginning practicum student can expect to attend a practicum seminar with all other students at the same level of training, as well as to have more regular and more intimate time with the faculty supervisor. During the seminar, issues common to all students will come up and issues specific to individual students will be discussed. In general, a practicum seminar also includes some type of presentation, some other didactic instruction, and a range of training exercises and activities, expecially role playing.

For example, a practicum supervisor is responsible for identifying sites as well as providing secondary supervision for all students. Students are required to attend a practicum seminar so that peer supervision can be accomplished. Students are encouraged to talk about their own experiences as well as individual cases and to share information and insights that might be useful for each of the students' activities. This seminar is conducted weekly and is attended by all students who are currently involved in a practicum experience. A distinction is made between advanced practicum students and early practicum students and, as a result, separate sections or seminars are conducted. In addition, the supervisor provides specific opportunities for individual supervision at the student's request or when the practicum director identifies a specific problem that needs some additional work.

At weekly sessions, weekly logs are submitted to the practicum supervisor so that the supervisor will be kept abreast of all the activities of the student at the practicum site. In addition, students are encouraged to talk about some specific issues of particular interest to them.

Critical issues to address in supervision at this level include: the trainee's own feelings about his/her own aging and about the aging of others, particularly in his/her own family; the development of empathy, especially through role playing, with older people in decline; awareness of the accessibility or inaccessibility of services for older people; and the difficulty many older people have in seeing mental health professionals.

Didactic instruction may be based on the student's needs as they are expressed and recorded in the practicum seminar sessions. Topics such as licensing gerocounselors, death and dying, and mental status examinations are but a few of the topics that appear to be of interest to students. Presentations by practitioners in the field may be scheduled for small groups of practicum students. Most of the topics are those that the student is more than likely to encounter on a regular basis in any kind of practicum site. Although they might be specifically relevant to one kind of professional activity, students find that the learning from these didactic instructional sessions is applicable in a variety of settings.

An advanced practicum student has the same experiences discussed in the preceding paragraphs, with the addition of more time spent working with particular clients or in particular areas. This may be the first time that a student is likely to present a tape of his/her own work for others to discuss (though this might be occurring on site as well); therefore, concerns about making a permanent record must be raised and thoroughly discussed. If taping and/or direct observation is not possible, the site might be dropped, since the trainee's progress becomes difficult to monitor. A client should never be interviewed by the supervisor for the purpose of assessing the student.

Issues to be explored in supervision at this point, in addition to those noted above, include: deviant patterns common in old age (especially isolation); crisis warning signs; when and when not to and how not to intervene — issues of rights to privacy, to treatment and to nontreatment; and death, both as a fact for clients and as a threat to the counselor's developing professional self-image.

Because an intern is much more sophisticated, s/he knows how to identify and raise an issue for discussion as well as how to accept criticism and advice. Among other issues that might come up in supervision at this point are: individual case problems, interaction with the medical world, presentation of self to the non-gerocounseling world, specific counseling techniques, third-party reimbursement (the issue of who pays for services and health insurance), and supervision.

The student's responsibilities involve keeping a log, behaving professionally at the site, admitting and correcting mistakes, accurate and thorough record-keeping, and providing audio or video recordings of relevant activities (this would include interactions with clients and might include records of meetings the student attended). The student should also read in topics related to the practicum/internship experience at his/her own and the supervisor's initiative, abide by the ethical standards of APGA, APA, and NASW and his/her own developing professional code, and share materials (tapes) and experiences.

The field supervisor should provide appropriate experiences in accord with the contract, have regular meetings with the student, answer questions and consult with the student about his/her ongoing activities, give the student feedback on performance at the site, provide the student with relevant information (organizational chart, performance guidelines, legal restrictions, enabling legislation, etc.) about the agency, and shepherd the student through introductions and into agency routine. The field supervisor should also hold formal and informal consultation with the academic supervisor and report to him or her.

Work has been done lately in triadic supervision (Spice & Spice, 1976) in which case material is discussed both with a supervisor and with peers. The material can be presented in any number of ways, but the most common methods are: audiotapes, videotapes, written and oral reports, and direct observation (of the student by either supervisor) in the same room, behind one-way glass or screens, by concurrent closed circuit telecasts, or even by volunteers.

The process of supervision involves giving and receiving feedback and modifying behavior, techniques, and goals. Choosing any of the types of supervision mentioned here depends so much on individual school situations that it would be difficult to give uniformly appropriate direction. The best advice, though, is that within personnel and other constraints a most useful course of action would be to try to maintain a combination of group and individual supervision throughout training. As indicated previously, on-site supervision is also an essential component.

As a guide to what to look for that might be peculiar to gerocounselor training, the reader is directed to the descriptions of specialized techniques and issues in other modules. The most common themes, or ageas of difficulty, are the reality of death and dying, depression related to loss or physical decline, the trainee's difficulty in confronting his/her own aging or that of parents, ageism in all its forms, dependency, and separation or termination (e.g., client-counselor, aging parent-adult child).

WHAT IF THINGS GO WRONG?

There are many difficulties that can arise for a student in practicum or internship. Most often, problems are resolvable and sometimes can be instructive. Particular areas of difficulty might arise from an unclear contract, from an agency expecting too high a level of performance, from a beginning student, from an ill-planned placement, from inadequate site supervision, from a temperamental mismatch, from violations of law or ethics, from mistakes, administrative changes at the practicum site, or unexpected events. The academic supervisor, field supervisor, and student should together be able to solve and overcome the problem. This may require rewriting portions of a contract, if one is used, but that is not necessarily a bad thing.

In any event, the supervisor must be prepared and willing to alter things significantly. In sequence:

- The problem must be identified, investigated, and articulated.
- The problem must be discussed among all the parties involved.
- Several resolutions, including alteration of the contract or changing the field or academic supervisor should be investigated (if the problem is academic or with the academic supervisor a regular academic advisor should be brought in).
- A trainee must be prepared to change sites if absolutely necessary and to lose time if staying in the problem situation will be counterproductive. In this case the school must make every effort to work with the student in overcoming the damage done to his/her progress and career, to the agency, to the school, and to all the attendant interrelationships.

The question of whether a supervisor actually has the time, competence and training to provide the necessary supervision for a gerocounseling student is very important. For example, in the case of a student who sought to work in a nursing home, a staff member who had acceptable credentials (master's level training in social work and a number of years of training in the area of gerocounseling) expressed a willingness to accept a student at that site. During a preplacement site visit by the school practicum director, however, it was revealed that this staff member in fact spent only two hours a week at the nursing home. This, of course, was inadequate for a graduate level gerocounseling student who would spend as much as 12 to 20 hours a week in practicum. Additionally, no other staff were qualified for supervision at that site.

What then are the student's options? In this particular case, it was determined through consultation with the prospective site supervisor that the student might do better to consider another site. In other communities, however, this may not be possible because of the infancy of the field of gerocounseling and the paucity of staff who meet the school's qualifications to be designated as site supervisor.

Some other options available to the student and the school in such a situation are readily apparent. For example, the faculty supervisor may need to increase his/her amount of time spent in supervising the student. Or if a more advanced practicum student, or preferably an internship student, is or can be placed in the same site, it may be possible to include supervisory duties as part of the advanced students' responsibilities. Supervision may also be provided by several staff within the agency whose qualifications and time spent on supervision collectively meet the school's criteria for supervision.

Clearly, other options can be exercised to develop new practicum sites and to establish a precedence to insure the continuation of new and multiple practicum settings for future students. In short, it is obvious that until the field of gerocounseling becomes more established, creative and innovative approaches to providing supervised experience will be necessary. Remember, though, that with good planning, smart scoutwork, and a well-conceived and executed contract or plan many difficulties can be anticipated and resolved quickly. It is important to remember that practicum and internship development by the parent school is an ongoing process.

EVALUATION

Evaluation of supervised experiences serves to provide the student with feedback and guidance about his/her development, to judge the student's performance against the expectations and criteria in the contract, and to determine whether and in what direction a student might move. These last two place a special burden on the faculty supervisor and are of a somewhat different nature than the first. In essence, two competing kinds of evaluation are going on concurrently, one a continuing process of give-and-take and growth enhancement and the other a static summary judgment of the whole experience and of the student as an emerging professional. It is the opinion of the author that the continuing process cannot be summarized in a letter grade or a simple summary statement; the static judgment often can be. Detailed descriptions of the trainee's progress, strengths, and weaknesses are recommended as written products for the process and these written reports together with a summary recommendation and grade of pass or fail, make up the judgment.

Ideally, the school and field supervisors, together with the student, should discuss and concur on the evaluation report entered into the files. In no event should a summary report's contents come as a surprise to any signatory to a contract; presumably, the ongoing process will have given an accurate indication of the final assessment.

There are many sources of data that can be used to evaluate a student's supervised experience beyond the crucial one of the supervisor's judgments. These include: the trainee's written products as the experience progresses (interview notes, case reports), self-evaluation material, the log, peer evaluations, client evaluations, and video- and audiotapes.

It must also be noted here that supervisors, supervisory settings, and supervision myst be evaluated. For example, over a period of time a number of students had been placed at a local office on aging. Contracts had been arranged with two supervisors at this site. The practicum director noted that in each case students had had their contracts modified without contacting the practicum director and had been reassigned to duties unrelated to the original goals of the practicum student. In some sases this was done with the student's approval and in other cases it was done as a result of more pressing demands for the agency. After consultation with the on-site supervisors, it was ascertained that the agency viewed the students not so much as trainees but as inexpensive volunteer labor. In this case the practicum director noted this for the record and stopped sending practicum students to the site. This is clearly a case in which students' needs and goals were not going to be realized or satisfied.

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APPENDIX A

Procedure for ADA Practicum

1. Initial interview with practicum director to discuss student's goals and explore possible placements.
2. Prior to site visit student will submit a statement of intent, detailing his/her learning objectives and proposed practicum activities.
3. Location of the site by student and/or practicum director.
4. On-site meeting of student, prospective field supervisor, and practicum director.
5. Letter of agreement sent from Antioch to field supervisor.
6. Field supervisor will confirm student's placement in writing.
7. Student begins practicum and attends practicum seminars.
8. Midterm assessment consisting of:
   - a. site assessment by practicum director
   - b. evaluation of student's performance by practicum director
9. Student will be responsible for integrating theoretical and experimental learning via:
   - a. development of a reading list (help can be provided with this if necessary)
   - b. journal
   - c. short paper
10. Student will make assessment of site and field supervisor.
11. Field supervisor will evaluate student's performance.
12. Final evaluation will be based on 6, 7, 8 and 9 above. Grading will be pass or fail only. No letter grade will be given.

MODULE XI

AGING-RELEVANT ISSUES, POLICIES AND LEGISLATION: WHAT THE COUNSELOR SHOULD KNOW

Charles E. Odell

Charles E. Odell retired in January 1977, as Commissioner on Aging of the State of Connecticut. He was appointed to that position in 1975 by Governor Ella Grasso after a long and distinguished career as Director of the U.S. Employment Service of the U.S. Department of Labor. Mr. Odell has been an active member of the APGA, serving on the Board of Directors and as president of both the National Vocational Guidance Association and the National Employment Counselors Association. He is presently serving as chairperson of the National Board of Elderhostel, Inc. and is immediate past chairperson of the Pennsylvania Council on Aging.

Author's Note: In October 1979, the President signed a Bill establishing a new Department of Education and changing the name of the Department of Health, Education and Welfare to the Department of Health and Human Services. An effort has been made to reflect these changes in the text. Wherever DHEW or Department of Health, Education and Welfare still appears, it should read DHHS or Department of Health and Human Services. However burdensome such changes may be in updating the text, they are welcome changes, nevertheless.

AGING-RELEVANT ISSUES, POLICIES AND LEGISLATION: WHAT THE COUNSELOR SHOULD KNOW

Rationale and Objectives

The aging and the aged are the fastest growing segments of the U.S. population. Because of ageism — discriminatory attitudes, policies, and practices — older people have not received their fair share of the nation's resources and services. Advocacy in behalf of a fair share for older people is therefore an important part of the counselor's responsibility in working with this age group. To be an effective advocate, a counselor must know what resources and services are available by law and regulation to meet the needs of the elderly and how effectively these resources and services are being used by the public, voluntary and private agencies, and institutions charged with the administration of services.

The objectives of this module are as follows:

(1) To describe briefly the relevant federal legislation and rule-making processes by which such legislation is implemented.

(2) To describe the so-called "network in aging" at regional, state, and local levels and to identify methods by which counselors can determine how well the network is carrying out the mandates of federal and state law and regulation in behalf of older people.

(3) To identify major public policy issues concerning aging and prospects for legislation affecting older people.

(4) To describe the role of counselors as advocates and to identify the political, social action, and educational resources through which advocacy can be channeled.

Content

RELEVANT FEDERAL LEGISLATION

For many years Congress and the Executive Branch of the federal government behaved as though Social Security was the only basic legislation for older people and nothing else need be considered. From 1935 to 1950, the first 15 years of Social Security, only technical amendments were made in the coverage and financing of the system. It was not until the early 1950s, when major international unions such as the Steelworkers' and the Auto Workers' pressed for company-funded pensions under collective bargaining, that concern for the broader issues affecting older people began to become a general political concern.

The first White House Conference on Aging, sponsored by President Harry S. Truman and the Federal Security Agency, was held in 1950. For the first time the full range of the legislative needs of older people were identified. In addition to an adequate income under Social Security, the first White House Conference on Aging identified needs in such areas as health care and its financing, housing, transportation, employment and retraining, social services, volunteer services, adult and preretirement education, professional training, and research. These needs were spelled out in a publication called Man and His Years (Federal Security Agency, 1951), which also described the need for national, state, and local organization for aging programs. As a result, an Office on Aging was established in the Federal Security Agency which later became the Department of Health, Education and Welfare, and a federal Interdepartmental Committee on Aging was also established. The conference also stimulated the creation of the National Committee on Aging of the National Social Welfare Assembly, which later became the National Council on the Aging.

During the 1950s, as a direct result of the first White House Conference, many states created offices on aging and there was a similar growth in community councils on aging in many major cities. These were the beginnings of the so-called "network in aging," which came to full fruition under the Older Americans Act of 1965.

Congress, however, continued to behave as though biennial adjustments in the level of Social Security benefits to account for increases in the cost of living were about all that was needed to take care of the needs of older people. But the biennial congressional review of the adequacy of benefit levels also resulted in substantial improvements in the basis Social Security program, including provisions for survivors' benefits, disability benefits, and extensions of coverage to public employees of state and local governments and employees of voluntary nonprofit organizations including educational institutions.

The most dramatic escalation in political concern for older people occurred with the introduction of the Forand Bill in 1957, which called for national health insurance under the Social Security Act for persons 65 and over. It took almost 10 years to get this legislation, later called Medicare, enacted, but in that 10-year period, several other less controversial pieces of legislation were passed including the congressionally mandated White House Conference of 1961 and the Older Americans Act of 1965.

The first congressionally authorized and sponsored White House Conference on Aging caused a quantum jump in public awareness and concern for the problems of the elderly. Thousands of local and state officials and representatives of private sector interests became involved in planning for, and participating in the Conference. The Conference report (U.S. Department of Health, Education & Welfare 1961) covered the same wide spectrum of interests and concerns as the 1950 Conference, but the depth and breadth of participation and media coverage ensured a much wider base for public education, understanding, and support for action. Representative John Fogarty of Rhode Island and Senator Patrick McNamara of Michigan, who had co-sponsored the White House Conference legislation, followed with the co-sponsorship of the Older Americans Act. The Act passed both houses of Congress unanimously and was signed into law in June 1965.

Other outgrowths of the 1961 White House Conference were the creation and strengthening of political and social action groups by and for older people, such as the National Council of Senior Citizens (NCSC), the National Retired Teachers Association (NRTA), the National Council on Aging (NCOA), and the American Association of Retired Persons (AARP). State and local organizations were also strengthened and the Association of State Administrators of Aging Programs came into being in the early 1960s. Senator McNamara was also successful in getting Senate approval for the creation of a Special Senate Committee on Aging in the early 1960s. That Committee, now paralleled by the Select Committee on Aging in the House, has acted as a vigilant watchdog or overseer of the progress and shortcomings of both Congress and the Executive Branch in dealing with various aspects of aging.

This very brief historical review is intended to make the point that Congress, even more than the Executive Branch, has become genuinely interested in the needs and problems of the elderly. With a few highly controversial exceptions such as national health insurance, Congress is likely to act favorably in providing basic resources and improvements in programs and services to older people. It should be noted that although programs for the elderly are likely to be approved by Congress, often the final level of funding is not as high as the initially proposed level. Consequently, a program cannot assure provision of the comprehensive services originally proposed.

The Older Americans Act, and its subsequent amendments, was a classic example of favorable action by Congress. A more recent example is legislation to eliminate the mandatory retirement age for federal employees and to raise it to 70 in the private sector (with specified exemptions discussed later in this module). This bill passed both houses of Congress overwhelmingly; the minor differences were resolved by a joint conference committee. This legislation is now Public Law 95-256.

BASIC LEGISLATION

Let us turn now to a very brief description of legislation designed to benefit the elderly. It is impossible to describe all this legislation in great detail here. The source of this comprehensive overview is a publication of the House Select Committee on Aging called Federal Responsibilities to the Elderly: Executive Programs and Legislative Jurisdiction (Select Committee on Aging 1977). In chart form, this publication identifies by broad functional service area and agency the resources and services available to older persons under existing law and regulations.

It is clear from this array of federal legislation and programs that there is a deep if diverse congressional commitment to programs and services for older people in the U.S. and that this commitment has been growing rapidly over the past 40 years. In January 1940, for example, the monthly benefits paid out by the Social Security Administration amounted to only $75,844. Today, payments exceed $5 billion a month, with checks going to more than 31 million people (Otten & Shelley 1976). Appropriations under the Older Americans Act were about $587,000 in 1965, but approached $402 million in 1979-80.

Each congressionally authorized program must be administered by the department or agency designated in the legislation and each department or agency must prepare and issue rules and regulations governing the administration of the law. This rule-making process is worthy of careful scrutiny and attention because there have been occasions when departments or agencies, or even the White House through the Office of Management and Budget (OMB), have attempted, in one way or another,

TABLE 1

Employment and Volunteer Programs

	Department of Labor			
Executive Agency Program	**Employment Standards Administration**	**Employment and Training Administration**	**ACTION**	**Small Business Administration**
Age Discrimination in Employment A.D.E. Act of 1967 (29 U.S.C. 621)	Individuals aged 40 through 64 are protected from discrimination in employment because of age by most employers of 20 or more persons; employment agencies; and labor organizations with 25 or more members.	*These functions were transferred to the U.S. Commission on Civil Rights by Executive Order as of July 1, 1979		
*A.D.E. Act Amendments of 1978 (P.L. 95-256)	*Removes age 70 as mandatory retirement for all federal employees except law enforcement fire fighters, air traffic controllers and foreign service beginning 9/30/78. Raises mandatory retirement age from 65 to 70 beginning 1/1/79 with the following exceptions: • application to tenured college professors delayed until 7/1/82 • Executives in private sector entitled to pensions of at least $21,000 a year.			
Community-Based Manpower Programs Comprehensive Employment and Training Act, 1973 (29 U.S.C. 801)		Funds are distributed to "prime sponsors" (States, Units of local government with populations of 100,000 or more) for providing work and training opportunities for persons of all ages wanting employment.		
*Community Service Employment Program for Older Americans Older Americans Act, Title V (42 U.S.C. 3001 et seq.)		Secretary of Labor may contract with public and private non-profit agencies to develop and administer part-time employment opportunities in public service activities for low-income persons aged 55 or older.		
Employment Programs for Special Groups Comprehensive Employment and Training Act, 1973 (29 U.S.C. 801)		Secretary of Labor may establish and operate training and employment programs for special groups, including older workers.		
Foster Grandparent Program Domestic Volunteer Service Act of 1973 (42 U.S.C. 5022, et seq.)			Federal grants are awarded to public and private non-profit agencies for creating volunteer service opportunities for low-income persons aged 60 and older to render supportive services to children. Volunteers receive $1.60 per hour.	
Retired Senior Volunteer Program (RSVP) Domestic Volunteer Service Act of 1973 (42 U.S.C. 5022)			Federal grants are made to public or private non-profit agencies to establish or expand volunteer activities for the elderly; compensation for out-of-pocket expenses incidental to their services is provided.	
Senior Companion Program Domestic Volunteer Service Act of 1973 (42 U.S.C. 5022, et seq.)			Grants are awarded to public and private non-profit agencies for creating volunteer service opportunities for low-income persons aged 60 and older who wish to render supportive service to adults, usually senior adults. Volunteers receive $1.60 per hour.	

Except where noted this and the following tables are taken from charts compiled by the Congressional Research Service of the Library of Congress for the U.S. House of Representatives Select Committee on Aging (*Federal Responsibilities to the Elderly: Executive Programs and Legislative Jurisdiction*, 1977)

*Added by module author

TABLE 1. Employment and Volunteer Programs (continued)

Executive Agency Program	Department of Labor: Employment Standards Administration	Department of Labor: Employment and Training Administration	ACTION	Small Business Administration
Service Corps of Retired Executives (SCORE) Domestic Volunteer Service Act of 1973 (42 U.S.C. 5033)				Retired professionals and businessmen assist persons with business related problems through local SCORE chapters established by the Small Business Administration.
Volunteers in Service to America (VISTA) Domestic Volunteer Service Act of 1973 (42 U.S.C. 4991 et sqe.)			Provides volunteer service opportunities for persons aged 18 or older in urban and rural poverty areas, on Indian Reservations, with migrant families, and in federally assisted institutions for the mentally ill and mentally retarded. Most older VISTA volunteers serve part-time.	

to thwart the will of Congress. Before formal promulgation, rules and regulations are prepared and published by the departments and agencies in the Federal Register in preliminary form; then for a specified period, usually a month or more, public interest groups, including affected state and local governments and private organizations, can review, comment, and propose changes in the regulations. This process is not well understood by consumers or their advocates. It is therefore important for counselors working with older clients and the agencies or institutions in which they are employed to seek access to such proposed rules and regulations, to review them, and to propose changes. Since this is a complex and highly technical process, it may require counselors to seek support and cooperation from their professional organizations or from social action agencies interested in older people to ensure the following:

1. The law is published and available for review within the specified period of time.
2. Congressional intent is accurately reflected in the wording of the bill.
3. Sections have not been omitted.
4. The intent of the law has not been distorted by the federal agency or department preparing the regulations.

THE NETWORK IN AGING

In the past a major problem with federal legislation and the management of programs authorizing services to older persons was the failure to provide effective mechanisms for planning, coordination, and creative use of available resources at state and local levels and even at the federal level. Although the Administration on Aging and the Interdepartmental Committee on Aging, established under the Older Americans Act of 1965, were supposed to achieve this coordination, there was no really effective follow-through at state and local levels until the Older Americans Act Amendments of 1973. These amendments provided, as part of Title III, for the establishment and funding in each state of Area Agencies on Aging (AAA) to plan, coordinate, and pool resources in order to improve the quality and variety of services available to older people in the geographic area served by each Area Agency. The 1973 Amendments also created the Federal Council on Aging out of what had been the Interdepartmental Committee on Aging.

Some states were reluctant to implement the AAA concept, but most have now done so, in whole or in part. This development has helped to achieve a definable and workable network in aging that runs from the AoA through regional offices with full-time professional staff to State Units or Agencies on Aging to Area Agencies on Aging. There are now about 600 Area Agencies on Aging. In some states the Area Agencies serve a common planning territory with other state human service agencies, such as those established for planning health and mental health services in the states. In other states, the territory served by the Area Agencies tend to follow more conventional political lines such as city, county, or multicounty boundaries. In still other states, particularly in the South and Southwest, AAAs are set up to serve the same geographical regions as those established for economic development planning.

(continued on page 310)

TABLE 2

Health Care Programs

	Health and Human Services				
Executive Agency Program	**Health Care Financing Administration**	**Health Services Administration**	**National Institute of Mental Health**	**Housing and Urban Development Office of Insured and Direct Loan Program**	**Veterans Administration**
Health Resources Development Construction and Modernization of facilities (Hill-Burton Program) Public Health Services Act, Title XVI (42 U.S.C. 291)		Federal formula grants and loans are made to public and private agencies, and to State governments for construction, expansion or modernization of long-term care institutions, and other outpatient and inpatient facilities. Federal share of project cost determined by designated State agency.			
Community Mental Health Centers Community Health Centers Act (42 U.S.C. 2681, et seq.)			Federal grants are provided to States to establish community mental health centers which provide comprehensive mental health services to low-income persons of all ages.		
Construction of Nursing Hones and Intermediate Care Facilities National Housing Act, as amended 1959, Section 232 (12 U.S.C. 1715 Z-1)				Federal government insures loans to non-profit agencies or individual sponsors to finance the construction, rehabilitation or equipment supply of certified nursing homes or imtermediate care facilities.	
Grants to States for Medical Assistance Programs (Medicaid) Social Security Act, Title XIX (42 U.S.C. 1396, et seq.)	Federal grants to states to cover 50-80% of costs of medical care for eligible low-income families and individuals. Within federal guidelines, states establish eligibility and scope of benefits.				
Program of Health Insurance for the Aged and Disabled (Medicare) Social Security Act, Title XVIII (42 U.S.C. 1395, et seq.)	Provides coverage of specified health care services for persons aged 65 or older and eligible disabled persons. Part A (Hospital Insurance) covers hospital and post-hospital skilled nursing home health services. Part B (Supplementary Medical Insurance) subject to premiums, covers physicians and other specified outpatient services.				

TABLE 2. Health Care Programs (continued)

	Health and Human Services			Housing and Urban Development Office of Insured and Direct Loan Program	
Executive Agency Program	Health Care Financing Administration	Health Services Administration	National Institute of Mental Health		Veterans Administration
Veterans Domiciliary Care Program (38 U.S.C. 5001-5002) (38 U.S.C. 641-643)					Federal funds for federal facilities; and project grants to States to construct and rehabilitate domiciliary care facilities for veterans. Facilities provide medical and personal care in residential type setting to aged and disabled veterans not requiring hospitalization; the program provides payments to facilities for provision of such services.
Veterans Nursing Home Care Program (38 U.S.C. 5031-5037) (38 U.S.C. 641-643)					Federal funds for federal facilities, and grants to States for construction of homes providing nursing home care to veterans, and for covering medical care services for veterans receiving such care.

TABLE 3
Housing Programs

Executive Agency Program	Housing and Urban Development			Agriculture Farmers Home Administration
	Office of Insured and Direct Loan Programs	Office of Assisted Housing	Community Planning and Development	
Housing for the Elderly The Housing Act of 1959, as amended, Sec. 202 (12 U.S.C. 1715 Z-1)	Federal loans for construction or rehabilitation of multifamilily rental housing for elderly (age 62 and over). Tenants may qualify for rent supplements under the Section 8 program.			
Low- and Moderate-Income Housing The Housing Act of 1937, as amended, Sec. 8 (42 U.S.C. 1437 f)	Provides housing assistance payments for low-income persons and families who cannot afford "decent and sanitary housing in the private sector." Rent supplements cover the difference between the community's fair market rent down to 15-25% of the tenant's adjusted income.	Responsible for management of Section 8 rent subsidy program.		
Mortgage Insurance on Rental Housing for the Elderly The Housing Act of 1959, as amended, Sec. 231 (12 U.S.C. 1715)	Federal government insures against loss on mortgages for the construction and rehabilitation of multifamiliy rental housing for the elderly (aged 62 or over) or disabled whose income is higher than the low or moderate income level.	Responsible for management of Section 231 mortgage insurance program.		
Rural Rental Housing Loans Housing Act of 1949, as amended, Sections 521 and 525 (49 U.S.C. 1490)				Federal government makes direct, and guaranteed insured loans to construct, improve or repair rental or cooperative housing in rural areas for low income persons including senior citizens aged 62 or over.
Community Development (Block Grant Program) Housing and Community Development Act of 1974, Title I, as amended (42 U.S.C. 4501, et seq.)			Formula grants to urban communities, based on poverty population and other economic and population factors, for variety of community development activities including construction of senior citizens centers.	
Low-Rent Public Housing U.S. Housing Act of 1937, as amended (42 U.S.C. 1401-1435)	Local housing authorities receive federal loans to aid in the purchase, rehabilitation, leasing or construction of multi-family housing for low income families, individuals aged 62 and over, and handicapped individuals. Housing designed for the elderly may have congregate dining rooms and other special features. Rents may not be more than 25% of the family's income.	Responsible for management of public housing program.		
*Congregate Housing Services Act of 1978 - Title IV, "Housing and Community Development Amendments of 1978 - P.L. 95-957, 10/31/78	Secretary may contract with local public housing and nonprofit corporations to provide meals, housekeeping aid, personal assistance and other services to maintain independent living.			

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*added by module author

TABLE 4
Social Service Programs

Executive Agency Program	Health and Human Services					
	Dept. of Education	Administration on Aging	Administration for Public Services	Community Services Administration	Treasury Office of Revenue Sharing	Legal Services Corporation
*Education Programs for Non-English Speaking Elderly Adults Education Act, as amended by 1973 Comprehensive Older Americans Service Amendments, Sec. 310 (20 U.S.C. 1201, et seq.)	Federal grants for state and local educational institutions, or to other agencies for education programs designed to serve elderly persons with limited English-speaking abilities, living in a culture different from their own, geared towards dealing with the practical problems of every-day life.					
Legal Services Corporation Legal Services Corporation Act (42 U.S.C. 2996)						Project grants to private non-profit organizations, universities, and Bar-sponsored organizations to provide legal services to low-income neighborhoods for those who cannot afford such services on their own.
Model Projects Older Americans Act, as amended, Title III (42 U.S.C. 3021, et seq.)		Federal project grants to develop projects designed to demonstrate new or improved methods of providing needed services to older people, focusing especially on housing, transportation, education, pre-retirement counseling and special services for older handicapped persons.				
Multipurpose Senior Centers Older Americans Act, as amended, 1973, Title V (42 U.S.C. 3021, et seq.) *1978 Amendments specify that Title V grants shall be made through AAA's.		The federal government may subsidize interests, award grants or insure mortgages for purchasing, leasing, repairing or altering a facility to serve as a multipurpose service center.				

*Added by module author

TABLE 4. Social Service Programs (continued)

Executive Agency Program	Health and Human Services			Community Services Administration	Treasury Office of Revenue Sharing	Legal Service Corporation
	Dept. of Education	Administration on Aging	Administration for Public Services			
*Nutrition Program for the Elderly Older Americans Act of 1965, as amended, Title III (42 U.S.C. 3001 et seq.) *1978 Amendments specify that Title VII nutrition grants shall become a part of Title III and all grants shall be made through AAA's.		Formula grants through State agencies on aging to public and private non-profit agencies to establish and operate low-cost group meals and home delivered meals for elderly persons 60 years old and older. The programs, located in community settings, include services introducing participants to other community resources and transportation to nutrition sites, where feasible.				
*Older Reader Services Library Services and Construction Act, as amended in 1973, Title VIII (20 U.S.C. 351, et seq.)	Formula grants through State Office of Education to public libraries to develop social library programs and services for the elderly, such as purchasing special materials for the elderly.					
Revenue Sharing State and Local Fiscal Assistance Act of 1972 (31 U.S.C. 1221, et seq.)					Direct payments to state and local governments based on a formula including population, poverty incidence, and state-local tax effort. Local governments may use these funds for B categories of services, including social services for the poor and elderly.	
Senior Opportunities and Services Economic Opportunity Act of 1964, as amended, Title II, Sec. 222(a)(8) (42 U.S.C. 2809, et seq.)				Grants are made available to community action agencies which fund projects providing economic, health and employment services and activities for low-income elderly not adequately served by more general programs under C.S.A.		

*Added by module author

TABLE 4. Social Service Programs (continued)

	Health and Human Services					
Executive Agency Program	**Dept. of Education**	**Administration on Aging**	**Administration for Public Services**	**Community Services Administration**	**Treasury Office of Revenue Sharing**	**Legal Services Corporation**
Social Services for Low-Income Persons and Public Assistance Recipients Social Security Act, as amended, Title XX (42 U.S.C. 1361-1371)			Formula grants to state welfare agencies to establish and operate social service programs for low income individuals meeting state income limitations. Services for the elderly may include information and referral services, home health care services, and other support services.			
State and Community Programs Older Americans Act of 1965, as amended, Title III (42 U.S.C. 3021-3025)		Formula grants to States to develop a comprehensive social service delivery system; establish area agencies on aging; and provide social services when otherwise inaccessible.				

TABLE 5

Income Maintenance Programs

Executive Agency Program	Agriculture Food and Nutrition Service	U.S. Civil Service Commission Bureau of Retirement Insurance and Occupational Health	Health and Human Services Social Security Administration	Railroad Retirement Board Bureau of Retirement Claims	Veterans Administration Compensation and Pension Service
Civil service retirement Civil Service Retirement Act, as amended (5 U.S.C. 8331, et seq.)		Principal retirement system for federal civilian employees; financed by employee contributions matched by employing agency plus congressional appropriations. Provides monthly retirement benefits based on past earnings and length of service to eligible retirees and their survivors.			
Food stamp program Food Stamp Act, 1964, as amended (17 U.S.C. 2016-2025)	Low-income families and individuals may buy food stamps worth more than the purchase amount, which varies with income. Persons over age 60 who are homebound, handicapped or otherwise unable to prepare meals may exchange food stamps for home delivered meals.				
Old-age, survivors Insurance Program (Social Security) The Social Security Act, as amended, Title II (42 U.S.C. 401, et seq.)			Financed through the payroll tax on employees, employers, and self-employed persons. Social Security pays monthly cash benefits to retired workers (their dependents or survivors). Entitlement and level of benefits is based on past covered earnings. Eligibility at age 65 or may opt for permanently reduced benefits at age 62.		
Railroad retirement program Railroad Retirement Act of 1935, as amended (45 U.S.C. 351-367)				Financed through a payroll tax on employees and employers. Monthly benefits are paid to retired workers (their wives and survivors) after 10 years employment in career railroad employment. Coverage for individuals with less than 10 years service is transferred to the Social Security System.	

TABLE 5. Income Maintenance Programs (continued)

Executive Agency Program	Agriculture Food and Nutrition Service	U.S. Civil Service Commission Bureau of Retirement Insurance and Occupational Health	Health and Human Services Social Security Administration	Railroad Retirement Board Bureau of Retirement Claims	Veterans Administration Compensation and Pension Service
Supplemental security income program Social Security Act, as amended, Title XVI (42 U.S.C. 1381, et seq.)			Aged, blind and disabled persons with no other income or with limited resources, are guaranteed monthly income. States may, and in some cases must, supplement federal payments.		
Veterans pension program (38 U.S.C. 501, et seq.)					Provides monthly cash benefits to veterans aged 65 or older with at least 90 days military service, including 1 day wartime service and who meet income limitation requirements. Benefits are also paid to designated survivor. Benefits may vary according to veteran's annual income.

TABLE 6

Training and Research Programs

	Department of Health and Human Services			
Executive Agency Program	Administration on Aging	Health Care Financing Administration	National Institute on Aging	Department of Education
Multi-disciplinary centers of gerontology Older Americans Act, as amended, 1973, Title IV-C (42 U.S.C. 3021, et seq.)	Grants to public and private non-profit agencies and institutions to establish or support centers for such activities as training personnel, research and demonstration projects, and consultation services.			
Nursing home care, training and research programs Presidential Directive, 6 August 1971		Project grants and contracts to provide short-term training for employees of long-term care facilities and for supporting studies on long-term care. Office of Nursing Home Affairs responsible for training nursing home inspectors and certifying nursing homes participating in Medicare and Medicaid programs.		
Personnel training Older Americans Act, as amended, Title IV-A (42 U.S.C. 3041-3042)	Project grants for training persons employed or preparing for employment in the aging field and for publicizing available career opportunities in the field of aging.			
Research and demonstration programs Older Americans Act, as amended, Title IV-B (42 U.S.C. 298-d, et seq.)	Project grants for research and demonstration projects involving the living patterns and living standards of the elderly and delivery of services to them.			
Research on aging process and health problems Public Health Service Act, as amended, Title IE (42 U.S.C. 298-d, et seq.)			Conducts and supports research relating to biological, behavioral and sociological aspects of the aging process and the special health problems of the elderly.	
Research on problems of the elderly The Higher Education Act of 1965, as amended by Older Americans Comprehensive Serivces Act of 1973, Title I (20 U.S.C. 1001, et seq.) (never funded)				Federal grants to institutions of higher learning to plan, develop and implement programs specifically designed to apply the resources of higher education to the problems of the elderly.

TABLE 7

Transportation Programs

Executive Agency Program	Department of Transportation Urban Mass Transportation Administration
Capital assistance grants for use by public agencies Urban Mass Transportation Act, as amended, Sec. 16(B)(1) (49 U.S.C. 1612)	Up to 2% of the annual allotment for capital assistance grants may be set aside for local public agencies for the acquisition of transit vehicles, equipment and facilities. Grants may be used to meet special transportation needs of elderly and handicapped individuals. The 2% funding limitation applies to both public and private nonprofit agencies (see Sec. 16(B)(2) below). Thus far, funds have been awarded only to nonprofit groups as public agencies qualify for funding under Section 3, 5 and 9 of UMTA.
Capital assistance grants for use by private non-pfotif groups Urban Mass Transportation Act, as amended, Sec. 16(B)(2) (49 U.S.C. 1612)	Up to 2% of the annual allotment for capital assistance grants may be set aside for private nonprofit groups to provide mass transportation services for elderly and handicapped individuals.
*Reduced fares Urban Mass Transportation Act, as amended (49 U.S.C. 1602 et seq.)	Mass transportation companies who receive federal funds for either capital or operating expenses must charge elderly and handicapped individuals no more than half fare during off-peak hours. Now applies to railroad (Amtrak) transit as well. Persons 65 and over can have half fares on a standby basis and 25 percent discounts for those making specific reservations. (Amtrak Legislation passed by Congress August, 1979).
Capital and operating assistance grants Urban Mass Transportation Act, as amended, Sec. 3, 5 and 9 (49 U.S.C. 1601 et seq.)	Grants to local public agencies are awarded under Section 3 for the acquisition and construction of mass transit vehicles; under Section 5 for capital and operating expenses; and under Section 9 for planning. These grants may be used for special services for the elderly.

(Text continued from page 300)

There is a continuing struggle between state units and Area Agencies on Aging for power and control of the funding available under the Older Americans Act. Although State Units have authority to deny funding, disapprove the area plan, or designate the AAA as an agency, they do not have direct administrative or line authority over Area Agencies. This creates many difficulties in carrying out federal and state mandates and is one of the major sources of friction between the State and Area Agencies.

Another source of friction is the existence of both public and voluntary planning and coordinating bodies in cities, towns, and counties. Much of this structure existed before the Older Americans Act Amendments of 1973 and some of it has not yet been brought into harmonious coordination with the planning and decision-making processes of the Area Agencies.

Additional conflict is found in the divergence of funding channels and regulations of other federal and state programs affecting older people. Federal revenue-sharing funds, for example, flow directly from the U.S. Treasury to cities, counties, and towns. Ensuring that older people get a fair share of such funds thus requires essentially local organization and political action by older people and their advocates, in which neither the State Units on aging nor the Area Agencies are necessarily involved. Manpower funds under the Comprehensive Employment Training Act (CETA) tend to flow in this same direction and present real difficulties to state and local agencies interested in the aging who seek to secure allocations of manpower funds for older and retired people who would benefit from training or job opportunities generated locally by CETA.

Even certain types of funding that flow through the aging network from the federal to the state level do not necessarily flow through Area Agencies. For example, funds for the nutrition programs under Title VII, which are by far the largest part of funding under the Older Americans Act, do not necessarily come through Area Agencies on Aging. In this instance direct funding is due to the history of the programs. Many of these programs were established in 1970 or 1971 as demonstrations under Title IV of the Act and many more were first funded under the 1972 Amendments that included Title VII. When Area Agencies began to be formed after the enactment of the 1973 Amendments, many of the nutrition projects had been operating for several years. The states therefore sought to retain the experience and expertise of the nutrition program workers in the delivery of this important social service. Despite efforts and exhortations from Washington to ensure joint planning and coordination of Title III and Title VII programs and ultimately to combine them into a single planning process, there is a great reluctance to do so in some states. The 1978 Amendments to the Act now mandate this.

A final complication in making the aging network function as intended is the proliferation of advisory councils and planning bodies through which state and area plans on aging must come before they can be funded. Each Area Agency has a board of directors as well as a consumer-oriented advisory council. Each State Agency has an advisory council. Each nutrition program or contractor sponsor has a board of directors and an advisory council. Public hearings must be held before area and state plans are completed for submission to the state governor and to the Secretary of HEW. Until 1979 area and state plans had to be submitted on an annual basis and by the time one plan had been developed, reviewed, and approved, it was usually time to initiate a new one. This left little time for plan implementation, review, and evaluation and no real opportunity for short- or long-term measurement of the impact of any particular portion of plans on the consumer — the older people for whom the services funded by the plan are intended. The 1978 Amendments to the Act require three year planning cycles with an annual update. They also require integration of planning and funding for all Titles including the old Titles III, V, VII and IX. These are major improvements which should greatly strengthen the network planning concept. The network concept in aging is now in place and is becoming more effective in planning, resource allocation, and coordination of service delivery. The network is becoming even more effective as a grass roots force for advocacy, including social and political action on legislation and appropriations at federal, state, and local levels.

MAJOR PUBLIC POLICY ISSUES

Social Security Financing

In its first session during 1977 the 95th Congress was confronted with the basic issue of Social Security financing and the long-term solvency of the Social Security fund. The Carter Administration recommended resolving this issue by increasing the wage base on which Social Security taxes are collected from employees, by taxing employers on all wages paid beginning in 1981, and by raising the tax rates beyond the increases already scheduled. The Administration's proposal would have permitted the Social Security trust fund to borrow money from the general treasury to make up for shortfalls that have accrued because of higher unemployment rates than were foreseen by actuaries when the present levels of benefits and taxes were projected in 1975. Congress resolved these issues by substantially increasing the tax rate and the wage base for both employers and employees in legislation signed by President Carter in December 1977 (now Public Law 95-216). The provision giving the Social Security trust fund authority to borrow from the Treasury was not included in the law.

The point for counselors and others serving older people to keep in mind is that there will continue to be a conflict in social policy with regard to Social Security financing. This means that basic decisions about benefit levels, coverage, and related issues such as cost-of-living adjustments, the work and earnings test, and lowering the age of eligibility, are usually resolved not in compassionate terms nor even in financial terms but in political terms.

Although employers and their trade association spokespersons object most loudly to increases in Social Security costs, they are the least likely to suffer since such taxes are deductible business expenses or are passed along in increased costs to consumers. It is the workers, particularly the young and middle-aged with family responsibilities, who are most adversely affected by the regressive nature of Social Security taxes.

As the number of older people living in retirement and dependent on Social Security grows, the burden on the young and middle-aged wage earners could become a major source of political and social unrest and discontent. This is perhaps the most important reason for shifting some of the burden of supporting Social Security from the regressive payroll tax to general revenues derived from the more progressive income tax.

Mandatory Retirement and Age Discrimination

The Age Discrimination in Employment Act Amendments of 1978 (Public Law 95-256) completely remove the mandatory retirement age of 70 for most federal workers, beginning September 30, 1978. Further, it increases the age for protection against mandatory retirement for workers in the private sector from 65 to 70, beginning January 1, 1979. The following exemptions are written into the bill:

- The application of the new upper age limit to tenured college professors and university faculty members is delayed until July 1, 1982.
- Persons employed in bona fide executive or high policy-making positions who are entitled to a pension of at least $27,000 a year are exempt from coverage under the amendments.
- The amendments do not apply to certain federal employees such as law enforcement and fire-fighting personnel, air traffic controllers, and Foreign Service personnel.

The legislative success of the Age Discrimination in Employment Act Amendment does not, unfortunately, institute the accompanying social change, needed to assure older workers of freedom of choice (to which we as counselors are presumably committed). In this context, age discrimination in employment, retirement, and other aspects of life is, or should be, abhorrent to counselors. Yet age discrimination in employment begins as early as age 35 or 40 in many occupations and is reinforced by pension and retirement policies that force people out of jobs simply because of age.

There are at least 1.5 million people 45 and over in the U.S. who are officially counted as unemployed and an equal or greater number who have given up looking for work because of age discriminatory practices. In the next 20 years, this group of perhaps 3 to 5 million persons will constitute those older people who live in poverty because their Social Security and pension benefits are wage-related and are adversely affected when they cannot find employment.

The legislation that eliminates mandatory retirement below 70 (with exemptions) confronts counselors with many new challenges in helping clients to get and hold new jobs. Such changes in the law should also stimulate employer and union interest in preretirement counseling and education because these may be effective tools for helping those who are reluctant to retire before 70 to consider retirement more completely and objectively.

Changes in mandatory retirement will also force a reconsideration of the ages of eligibility for pensions and Social Security. Former Secretary of Commerce Juanita Kreps once proposed raising the basic age of eligibility for full Social Security benefits from 65 to 68 to permit and encourage more older people to continue working if they are willing and able, thereby reducing the costs of the Social Security system. The proposal has been withdrawn but the implications of such innovations should be further explored as possible courses of action.

The courts are also contributing some confusion to the issue of mandatory retirement as a discriminatory employment practice. In Murgia vs the Commonwealth of Massachusetts (1975), the Supreme Court ruled that the Massachusetts State Police could mandatorily retire a state policeman with long service and good health on grounds of the hazardous nature of his profession. It is interesting that Murgia was assigned to administrative work and was very unlikely to see any of the hazardous duty on which the decision was justified.

In a December 1977 case, McMann vs United Air Lines, the Supreme Court ruled that McMann, a pilot, could be mandatorily retired at age 60 since the provisions of the pension plan under which he was retired preceded the passage of the Age Discrimination Act of 1965. The Supreme Court's decisions to date on age discrimination are not very encouraging and suggest the need for Congress to clarify their intent with regard to the status and effects of existing pension plans and policies on future retirement practices. A current update (Peavey 1977) on court decisions in age discrimination cases appears in the September-October 1977 issue of Perspective on Aging.

A related issue now under consideration in Congress is the elimination of the earnings test or earnings limitation under Social Security. The House passed amendments that eliminated the earnings test. The Senate passed a bill compromising on the issue by continuing a more liberal earnings test for those under age 70, but eliminating the earnings test for those 70 or over.

Costs in the Delivery of Health Services to Older People

Experts in geriatric and preventive medicine argue that our present system of financing and delivering health care services, particularly for older people, make the ill poor and the poor ill. By this they mean that the emphasis on payment for treatment of the elderly sick rather than on payment for measures to keep them well as long as possible are cost ineffective. The costs of Medicare and Medicaid were estimated to exceed 11 billion dollars a year in 1978 and there is no end in sight. It is also estimated that from one third to one half of the frail and the terminally ill elderly who are now institutionalized could be treated at home at about half the present cost of institutionalization. Yet in the U.S. there is no basic commitment to delivering and financing comprehensive health care for older people. There have been experimental and demonstration programs such as Triage in Connecticut (Older American Reports 1977), but there is no clear commitment by the Administration or Congress to incorporate the concepts of comprehensive home care in a national health insurance package.

Again, it is the issue of costs and financing that seem to stand in the way of a practical solution. Ideological issues of course are also involved. The powerful American Medical Association continues to oppose government intervention in establishing systems, standards, fee schedules, and professional review procedures to control the quality and cost of medical care. The Carter Administration, which had announced its intention to introduce a comprehensive national health insurance bill for consideration in the second session of the 95th Congress finally presented a piecemeal proposal in June of 1979 which calls basically for a catastrophe illness coverage underwritten by employers, workers and providers through the private health insurance companies.

In the meantime, some of the very basic services that would keep older people well and out of institutions are not funded under Medicare nor would they be under the Administration proposals. For example, eye care, hearing care, dental care, and foot care are not adequately covered. Such restrictions are penny-wise and pound-foolish since it is obvious that people who cannot eat properly are more likely to become ill through malnutrition; people who cannot see properly are more likely to trip and fall, causing fractures that often are permanently disabling, etc.

Although Medicare and Medicaid have been boons to many older people faced with expensive hospital stays, surgery, and long-term post operative care, the experts believe that cost restraints on hospital and surgical care, along with more adequate payment arrangements for preventive care and home care, would greatly reduce the overall costs of health care for the aged. Abuses in the delivery of care to the elderly in hospitals and nursing homes, highlighted in state and federal investigations in the past five years, precipitated the House of Representatives into requiring the Administration on Aging to support technical assistance and training for the ombudsman program funded under the Older Americans Act.

The ombudsman program, which requires states to provide a mechanism for responding to the complaints of nursing home residents and for taking positive steps to improve conditions by working for changes in state laws and regulatory practices in the field has been reasonably effective in some states. Counselors working with the elderly need to be aware of these developments — not only to protect their clients from exploitation but also to be able to assist them in finding alternative methods and systems of care that are less expensive and more appropriate to their personal and family needs and circumstances.

Education, Recreation and Social Services

Preoccupation of the media and politicans with the bread and butter issues of Social Security and health care has created the false impression that the vast majority of the nation's 32 million people 60 and over are frail and impoverished, living in nursing homes or homes for the aged. Actually only about 5 percent of those over 65 are institutionalized. In fact, the vast majority are reasonably healthy, mobile, and able to take care of themselves, given reasonable and relatively inexpensive access to available community resources and services.

Educational and recreational institutions at all levels and in all settings have been slow to provide such access to older people. Some states now offer free tuition to older people in community colleges and state-supported colleges and universities, but few states are aggressively promoting the participation of older people. Some school systems have reached out to provide adult education opportunities to older people and a few have even built special facilities in new school buildings to serve as senior centers. Some local and state recreation departments, such as in New York, have provided financing through matching funds for senior centers and preretirement education programs. Congress has finally provided token funding for the renovation and remodeling of senior centers under Title III of the Older Americans Act, HUD's Small Cities Program, and revenue-sharing funds, but by and large the senior center movement has had to depend on local and state funding from public and voluntary sources.

The whole issue of adequate funding and support for programs designed to give opportunities for the creative use of retirement time remains unresolved in the U.S., although some progress has been made. From a handful of multipurpose senior centers in the nation in 1960, we now have close to 10,000 (National Institute of Senior Centers 1974) today, but most of them are inadequately housed and staffed to serve the wide range of needs of potential consumers.

Although many older people express reluctance to get involved with their peers, that is, to be identified with a club or center serving senior citizens, substantial numbers find satisfaction and a new life style when they actually become involved. Counselors need to be aware of the availability and adequacy of education, recreation, and social service resources for their older clients. They can also be instrumental in improving the quality of the personnel and resources available to older people by sharing their professional expertise and experience with educators, administrators, social workers, and paraprofessionals involved in such programs.

A point often overlooked by educators and recreation officials is that older people who own their own homes contribute a major source of support, through property taxes, for local and state education and recreation programs. Many school bond and millage issues have been defeated because the majority of older voters voted them down. Opening up facilities and services to older people is now seen by enlightened educators and recreation leaders as a way of demonstrating to older taxpayers that they have a stake in better schools and recreation facilities. Counselors who serve older people can help to bring this insight to the attention of school administrators.

Housing and Transportation

Transportation is often listed as the most important unmet need of older people (Harris & Associates 1975). Substantial progress has been made in providing transportation to the limited numbers of older people who participate in organized congregate programs such as the nutrition programs under Title III of the Older Americans Act, the senior center programs run by local public and voluntary organizations, and the special programs providing services in the home under Title III, in which some mobility is necessary for purposes of shopping, doctor appointments, and so on.

Under recent amendments to the Urban Mass Transportation Act many states and localities are qualifying to provide reduced fares for those over 60 on publicly subsidized mass transit systems.

A few states, like Pennsylvania, have used substantial funds from the state lottery to subsidize mass transit for older people.

The vast majority of older people, however, are still not reached by these programs. Transportation and support for greater mobility for the urban, suburban, and particularly the rural elderly remain major areas of unfinished business in congress and in the states. A related issue is the need for specially designed mass transit vehicles and facilities for the physically handicapped and the elderly. Buses with folding stairs and lifts for those in wheelchairs and others who have difficulty climbing steps are now being produced in substantial numbers by major bus manufacturers. To meet the increased costs for such buses, some major cities are joining together to pool their procurement funds, thereby guaranteeing the manufacturer a volume, mass production market.

Housing

The elderly housing issue is even more complex. Many older people continue to live in older properties in the older sections of town. The taxes on these properties continue to rise and the costs of maintenance and repair have skyrocketed. Building or purchasing a new home is frequently beyond the reach of older people living on fixed incomes. Furthermore, the suburbs are still relatively lonely places for older people, although this is changing as suburban neighborhoods themselves age. Most new, low, or middle income housing for the elderly in the North and West has been high-rise housing built under the Housing Act of 1937 or under the nonprofit housing provisions of the Housing Act of 1959. Very little of this housing is designed or located to adequately provide a well-rounded way of life for older residents. Moving to a warmer climate or to special retirement villages designed and built for older people has been very popular in the past 25 years, but for low and middle income older people, most of this type of housing is prohibitively expensive.

Public policy on housing for older persons certainly needs a comprehensive review in Congress and in state legislatures. Because of cost alone, new construction is increasingly beyond the reach of the vast majority of older people. Most, however, would prefer to remain in their own homes and neighborhoods, provided they have adequate protective services, transportation, access to shopping, and needed public services. The rising costs of energy also complicate the housing and transportation problems of older people. Sooner or later older people will require substantial housing and transportation subsidies and/or tax breaks in order to maintain themselves in secure and hospitable surroundings.

Counseling and Preretirement Education

The American Personnel and Guidance Association's Committee on Aging sponsored legislation in the 94th Congress to provide comprehensive counseling services to older people. This legislation was introduced by Representative Claude Pepper, Chairman of the House Select Committee on Aging. It would establish a new title under the Older Americans Act and authorize substantial funding for counseling older people channeled through State Units and Area Agencies on Aging to service-provider organizations. Special hearings were held on this proposed legislation at the APGA Convention in Dallas in March 1977 (Select Committee on Aging 1977).

It is doubtful that Congress will act on this legislation in the current session unless counselors and their organizations show interest and support through educational and lobbying activities on Capitol Hill. The counseling profession, as represented by APGA, is not regarded by administrators and practitioners in the delivery systems for services to the aging as a primary service resource, even for counseling assistance. For example, Otten and Shelley in their recent book, When Your Parents Grow Old (1976) do not mention counselors in the APGA context as referral resources. On the other hand, they do place heavy emphasis on social workers and social work agencies as referral resources. This suggests the need for a wider basis of understanding and support for counseling services to older people within APGA and its constituencies. Perhaps this training project will increase counselors' awareness of the counseling needs of older people. It is hoped that the completed training package will also enhance the credibility of APGA and its membership in relationship to other professional organizations such as NASW, the Gerontological Society, and NCOA.

Training and support for pre-retirement education and counseling is another important aspect of the APGA-sponsored comprehensive counseling bill. Although many companies and unions claim to conduct such programs, very few of them are staffed by professionally trained and experienced counselors. It has been difficult to gain labor and industry support for preretirement education by professionals. As Kunze pointed out (1973) in a special issue of the Personnel and Guidance Journal on the employment outlook for counselors, it is difficult to convince industrial management that professional counseling pays off on the bottom line. Organized labor is also resistant to hiring professional counselors, preferring to designate and train their own leadership to provide limited assistance to older and retired members. Most preretirement assistance offered by both labor and management tends to be in the form of information-giving, with very little in the way of professional group or individual counseling.

Some State Agencies on Aging, including those in Connecticut, New York, Michigan, Iowa, and others, have developed formal preretirement education programs. Both the Department of Labor and the Administration on Aging have funded demonstration projects in preretirement education, but there is still a need for a firm base of support through laws and funding resources in order to develop and sustain a comprehensive approach to preretirement education and counseling on a nationwide basis.

Perhaps the new age discrimination law will encourage management and labor to reexamine their attitudes and behavior toward preretirement education and counseling. Certainly one way to deal with the issues involved is to offer positive professional assistance to older employees. These and other social policy issues are more fully explored in "You and the Senior Boom" (Odell and Odell, 1980).

Research and Training Directions in Aging

Robert N. Butler, Director of the National Institute on Aging and Pulitzer-Prize-winning author of Why Survive — Being Old in America (1975), has rather carefully and conservatively documented the significance of aging research and training developments in his book. Butler is not optimistic about early breakthroughs in aging research that will radically increase the life span of today's older people or life expectancy at birth. He does emphasize the need for a greater investment in public and voluntary funding for preventive medicine and a greater concern for the development of interdisciplinary research and training efforts.

The National Institute on Aging (NIA) was established in October 1974. It supported about 150 research grants in fiscal year (FY) 1976 on a budget of approximately 17.5 million dollars. Congress increased its funding in FY 1977 to 30 million dollars, which made possible an increase to about 250 research grants. The NIA also supports about 100 research training awards to pre- and postdoctoral fellows carrying out the types of research NIA supports (Special Committee on Aging 1977).

During the second term of President Nixon (succeeded by President Ford), the Administration failed to recommend funding for research and training under the Older Americans Act (Titles IV-A & B). The Nixon-Ford Administration also resisted the creation of NIA, exemplified by an early veto. Congress has continued to fund research and training under Titles IV-A and IV-B and under NIA. Fiscal year 1976 appropriations for Title IV-A were 14 million dollars; for IV-B, 10 million dollars; for NIA, 19.2 million dollars. Portions of these funds have been used to support grants to colleges and universities for career training, development and quality improvement training, and conferences. A portion of the Title IV-A funds also goes to State Agencies to support staff and manpower development efforts, with a further provision that 50 percent of each state's allocation shall be used to train Area Agency staffs and/or the staffs of their grantee agencies at the local level.

About 10 million dollars was allocated for research and demonstration projects under Title IV-B in FY 1976. Title IV research funds were used to support 72 grants and contracts during FY 1976. A detailed description of these awards is presented in the annual report of the Senate Special Committee on Aging (Special Committee on Aging, 1977, see pp. 112-113). Twenty colleges and universities were also supported by Title IV-C multidisciplinary center grants in FY 1976; seven of these were operational grants and 13 were developmental grants.

These details indicate a potential for funding for counselor training institutions and for counseling-related aging research in the ongoing programs of the NIA and the Administration on Aging. It is significant that little, if any, of this funding now goes directly for counselor training or to fund counselor education or counseling-related research programs. Hopefully more such funding will occur as the results of this grant and a follow-up training grant now being implemented begin to impact the counselor education and continuing education networks across the nation.

Advocacy Role of the Counselor

For counselors advocacy means a commitment to seeing that the clients' needs, as perceived in the counseling process, are met as quickly and completely as possible. Obviously, some of these needs can be met by professionally sound and compassionate counseling services that are clearly within the existing knowledge and competencies of the counselor. But many of the needs involve social and political action that may go beyond the traditional skills of the counselor.

As we look at the wide range of existing legislation, regulations, and appropriations and the even wider range of emerging issues in the field of social gerontology, it becomes clear that counselors working with older people have a challenging role to play as advocates. Since most counselors work in institutions and agencies that are publicly funded, they, like educators and other public servants, have been very reluctant to become too directly involved in political and social action. As counselors are trained to serve older people and as they are assigned to work with them on a full- or part-time basis, it is hoped that this will change.

Clearly, the older clients' needs are the best sources of information and ideas as to where the counselors' priorities should be directed with regard to advocacy. These needs will range across the spectrum of the functional areas already described in this module. Traditionally, counselors have been trained to meet these needs by referring clients to the appropriate agency or agencies for the services and assistance required. But referral to other agencies, particularly for older people, is no guarantee that services will be provided. As an advocate, the counselor must be prepared to follow up and follow through to see to it that the client finds the proper agency and gets the assistance required.

If the service is not provided, the counselor as advocate has the responsibility for determining why not and then seeking to help the client get the service or benefit, if at all possible. Such aggressive involvement will help the counselor to determine which services and benefits are for real and which are for public relations only. It will also help the counselor to determine what further steps must be taken on an individual or group (social action) basis to change regulations or legislation to ensure that the clients' needs are met.

Although counselors as individuals working to help individual clients can do much to improve things, many of the unfulfilled needs of individual clients are symptomatic of significant deficiencies in resources and services that will require broader-based political and social action. For this purpose, counselors in their advocacy role must know how to gain access to other sources of support for political and social action. The network in aging described earlier is the logical place to start in seeking allies for political and social action. The network has the advantage of starting at the grass roots or local level, with lines upward from local public and private agencies to Area Agencies to State Units on Aging to the regional and federal offices of the Administration on Aging. One way of gaining access to the network is to seek representation on local, area, or state agency advisory councils; if that is not possible, contact influential advisory council members and ask for their support. The public hearings process under the Older Americans Act and other federal statutes, which is supposed to include consumers and their advocates as part of area and state planning, also gives counselors an opportunity to express their views on issues of concern to older clients.

Direct contacts in personal meetings, by phone, or by mail with local elected officials, state representatives, congressmen, and senators are another avenue of effective advocacy. Such contacts are most effective when they are very specific and when they can result in some action that is understandable to the elected official. Frequently such officials will express sympathetic interest but will offer little or no encouragement on the grounds that there is no evidence in their mail or their contacts of a widespread interest in the issue at hand.

To deal with this kind of response it may be necessary to create a ground swell of support by making contacts with other individuals and groups that should be interested in the issue. Professional colleagues in APGA, its state, local, and divisional branches could be contacted as one source of support. Local branches of senior citizens' organizations, such as the National Council of Senior Citizens, the AARP-NRTA, and local affiliates of federal and state government retiree organizations, are also good sources of political and social action support.

Political candidates and political party leaders are also potential sources of support for creating interest where it counts in new or amended legislation, increased appropriations, or changes in regulations that will improve services to older people. Sometimes it is easier to get support from an incumbent by having the opposition's support, particularly during an election campaign. The "me too" syndrome in politics is often a very effective way of getting action on an issue, in this case issues affecting older persons.

Finally, effective advocacy will require the development of coalitions among all the individuals and organizations mentioned above. Some states have already begun to develop legislative coalitions in support of basic changes to improve services to older people in the state. Counselors in their advocacy roles should identify the leadership of such coalitions and try to establish ongoing working relationships with one or more of the leaders.

Advocacy in behalf of older people can be complex, time-consuming, and even rather frustrating. But it will also prove to be rewarding, if only because there is a growing interest in older people, particularly on the part of elected officials who study voting trends and patterns. The growing number of older people in the general population is of particular interest to politicians because the proportions of older people who are registered to vote, who vote in party primaries, and who vote in general elections are substantially greater than their proportions in the general population (Kedig & Warren 1976).

These data should also be of interest to counselors, who have traditionally worked primarily with young people in schools and colleges where enrollments are declining and financial support has stabilized or dropped. It may well be that the survival of counseling services in schools and post-secondary institutions depends on the increased support of older people who see themselves as beneficiaries of counseling services that reach beyond the institution into the community at large.

Implications for Counselors

What is intended here is a brief recapitulation of the major implications for counselors under each heading in the content section.

RELEVANT FEDERAL LEGISLATION

In view of the wide range of problems and issues represented in a clientele of older people, counselors should have a general familiarity with the breadth of federal legislation affecting this new clientele. Counselor educators using this module will have to encourage students to explore the detailed provisions of federal laws and regulations concerning benefits and services to older persons. This can probably best be accomplished by assigning students to develop more specific information in each of the functional areas to share with fellow students in both classroom discussions and written presentations.

THE REGULATION AND RULE-MAKING PROCESS

Counselors need to understand the regulation and rule-making process and how to relate to it since it will affect them and their clients. The most effective practitioners are those who know the rules and regulations and how to cope with them in everyday practice. It is also important to know where to go for help in getting knowledgeable interpretations of the regulations.

THE NETWORK IN AGING

Although the concept of the network may not be fully operational in every state and locality, it is important for counselors to know what the network is supposed to be and how it operates (or fails to operate) in the geographic or political area in which they will be employed. Information about the network will also be important to a practitioner in finding employment, in locating referral resources, in seeking financial support for the initiation or continuation of services, and in developing contacts for advocacy in the political and social action arena.

MAJOR POLICY ISSUES

This section is intended to describe and to encourage discussion of some of the major areas of unfinished business relating to social policy for older people. There are many additional issues that might have been discussed but the few that have been presented here will serve to stimulate thinking among students and teachers as to where we are and where we ought to be going as a nation. We pride our nation on its devotion to the principle of freedom of choice, but we have not really pursued political and social policy consistent with that principle in our dealings with older clients.

THE ADVOCACY ROLE OF THE COUNSELOR

This section is most important since it relates to effective delivery of services to the aging and the elderly. As other modules point out, older people are discriminated against in our society, not only in employment and retirement policy but in most or all facets of life. The seemingly simple goal of a "fair share of the nation's resources" will be hard to achieve without a growing commitment to militant advocacy on the part of professionals and paraprofessionals serving older people. Unfortunately this cannot be done by well-meaning professionals alone. Counselors must learn to work with others, not only within the publicly funded networks, but in the broader arena of political and social action. Professionals can work through elected officials, public interest groups, allied professional organizations, and organized groups of consumers, such as the National Council of Senior Citizens, AARP, NRTA, and the various union and public employee retiree groups that exist in every state and in most communities.

Individual/Class Activities

The following individual student and class activities are probably essential to the meaningful presentation of this module because it attempts to cover so much ground in a limited time. This means that the instructor will have to encourage, if not require, individuals and groups of students to undertake the following types of activities and projects outside class:

BASIC FEDERAL LEGISLATION

1. Assign individuals or groups to develop a detailed written presentation on each piece of relevant federal legislation, for example, the old age and survivors insurance portions of the Social Security Act, the Older Americans Act, and the Age Discrimination in Employment Act. If these assignments are presented in a more or less uniform format, they can be shared by all members of the class to become part of a basic reference guide on federal legislation. (A similar series of assignments should be made dealing with state legislation.)

2. Assign individuals or groups to develop a detailed analysis of legislation in each of the functional categories in the charts presented on pages 299 to 310. These analyses could then be presented verbally in class or shared among students in written form to provide a comprehensive reference guide to federal legislation in aging.

3. Assign individuals or groups to survey the impact of federal legislation and appropriations on state and local agencies and on organizations providing services and programs for older persons. The results of such surveys can then be shared in classroom presentations or in written form among students and instructional staff.

THE NETWORK IN AGING

1. Individuals or groups of students should be assigned to explore and chart the nature and design of the network in aging in the state. This can be done by inviting appropriate State or Area Agency officials to class to present their impressions on the network and how it operates or by sending students to interview appropriate State and Area Aging staffs.

2. Assign students to contact the Area Agency on Aging in their own part of the state and to determine how that agency actually operates, in particular in its emphasis on funding agencies to provide counseling and other human services such as information and referral, case finding, case management, and the delivery of counseling and other social services to older people in the home, in congregate sites (senior centers, housing or meals programs), or in community health, mental health, and social service agencies. The purpose is to help students in getting a feel for the network — whether it really exists, how it works, how it relates to other agencies and programs, how well it involves consumers (older people) in its planning, and how the consumer, the general public, and the political power structure feel about it.

SOCIAL POLICY ISSUES

Those presented in the module are by no means all inclusive, nor did space permit a full exploration of their implications. Individuals or groups of students could be asked (or assigned) to develop brief working papers on each of these and other policy issues. State and local officials, state legislators, congressmen, and senators are also good sources of information and ideas on issues. Local representatives of retiree and senior citizen groups also have legislative committees that can provide useful information and ideas. Because many of these issues are controversial, it will be useful to invite opinions and viewpoints from both political parties and a variety of local groups. Classroom debates involving students or invited guests will be an interesting and stimulating way to discuss public policy issues if time permits.

THE ADVOCACY ROLE OF THE COUNSELOR

Individuals or groups can be asked or assigned to determine when basic issues affecting older persons are being discussed or acted on in such forums as city or town councils, AAA plan hearings, State Agency plan hearings, legislative hearings in the state legislature or Congress and to arrange to attend and participate in such hearings. Contacts can also be made with political and social action groups to determine how they operate and what issues are currently important to them. A study of the current status of the budget for State Units in Aging, Area Agencies and nutrition projects under both state and federal appropriations will be revealing of the need for and effectiveness of advocacy within the state.

References and Related Resources

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ADDITIONAL RESOURCES

Publications:

1. Annual reports of the relevant federal, state, and Area Agencies, as well as those of the appropriate congressional and state legislative committees are excellent sources of current information and status reports on developments in aging. These may be secured by writing to the appropriate agencies and committees, including:
   a. Special Senate Committee on Aging, Chairman — Senator Senator Lawton Chiles of Florida.
   b. House Select Committee on Aging, Chairman — Congressman Claude Pepper of Florida.
   c. Administration on Aging, DHEW, Commissioner — Robert Benedict.
   d. Federal Council on Aging, Chairman — Nelson Cruickshank, Counselor to the President on Aging, The White House, Washington, D.C.
   e. Director or Commissioner of the State Department, Division, or Unit on Aging at the state capitol.
   f. State legislative committees in the state senate or the house or joint committees at the state capitol.
2. Reports of Hearings by Congressional Committees: Available on a wide variety of subjects. May be secured by getting on the mailing lists to receive hearings when they are published by writing to the appropriate committee chairman (as indicated above).
3. Regular publications and journals of organizations serving older people. Secured by subscription or membership from:
   a. *The Gerontologist*, Gerontological Society, One Dupont Circle, Washington, D.C. 20036.
   b. *Senior Citizens News*, National Council of Senior Citizens, Investment Bldg., 15th and K Sts., N.W., Washington, D.C.
   c. *Modern Maturity*, monthly publication of NRTA-AARP, 1909 K St., N.W., Washington, D.C. 20049.
   d. *Perspectives on Aging*, a bimonthly publication of the National Council on Aging, 1828 L St., N.W., Washington, D.C. 20036.
   e. *Older American Reports*. biweekly update on national developments in aging, Plus Publications, Inc., P.O. Box 64014-C, Baltimore, Maryland 21264.
   f. *Aging*, monthly publication of the Administration on Aging, DHEW, Washington, D.C.
   g. Most State Units and many AAA's publish monthly or quarterly reports.

Films and film strips: Allyn, M.V. *About aging: A catalog of films, third edition*. E.P. Andrus Gerontology Center, University of Southern California Press, Los Angeles, California, 1977.

Reference libraries and bibliographies:

1. National Council on Aging
2. American Association of Retired Persons
3. National Clearinghouse on Aging, Administration on Aging
4. Bibliographical Updates — Lists of new acquisitions to the NCOA library, 1828 L St., N.W., Washington, D.C. 20036.

BASIC LEGISLATION

Each student should have a reasonably complete documentation of current federal legislation in guidebook or outline form, based on individual effort or shared materials from others in the class who have prepared materials for sharing purposes. Instructors should review these guidebooks to see that they are complete and in good order as one basis for evaluation of individual and class performance on this module.

NETWORK IN AGING

Each student should be able to draw an organizational chart showing the structure of the network in aging in the state and in the student's own place of work or residence. The names of key persons in the network should be shown on the chart.

SOCIAL POLICY ISSUES

Each student should be asked to develop a basic position paper on one of the major social policy issues discussed in class. This should include the pros and cons of the issue and should identify the positions of the major political parties and the short- and long-range fiscal implications that can be projected if positive action on the issue is taken by Congress or the state legislature.

ADVOCACY ROLE

Each student should be asked to describe in reasonable detail the steps to be taken in order to be an effective advocate for older people on a particular issue, which may or may not be an issue outlined in the social policy section.

This subject and author index is published as a supplement to the original *Counseling the Aged* training syllabus. Future editions of the training syllabus will contain this index.

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Three New Manuals on Counseling Older Persons

The American Personnel and Guidance Association/Administration on Aging National Project on Counseling Older People has developed three new manuals. These manuals comprise a set designed to facilitate the development and implementation of interpersonal communication and helping skills training programs for service providers who work with older people.

Counseling Older Persons, Volume I, Guidelines for a Team Approach to Training, 1981. Jane E. Myers, Pamela Finnerty-Fried, Carolyn H. Graves, Editors. $14.50 to APGA members; 17.50 nonmembers (Order #72107).

A blueprint or action plan for developing gerontological counseling training programs is presented by describing a planning team drawn from areas of program development, implementation, evaluation, and institutionalization. In addition, the manual includes descriptions of programs that were actually developed and implemented nationwide as a result of the National Project on Counseling Older People.

Counseling Older Persons, Volume II, Basic Helping Skills for Service Providers, 1981. Jane E. Myers, Editor; Mary Ganikos, Junior Editor. $15.75 to APGA members; 18.75 nonmembers (Order #72108).

This manual is designed as a text for a communication skills training program for service providers in the aging network. With the guidance of an expert trainer, this manual can be used to teach service providers basic helping and communication skills so that they will be more effective in serving older persons. It is written in lay language and uses a workbook format.

*Package price for all three volumes purchased together is $40.00 to APGA members; 49.00 nonmembers (Order #72105).

Counseling Older Persons, Volume III, A Trainer's Manual for Basic Helping Skills, 1981. Jane E. Myers, Editor. $15.75 to APGA members; 18.75 nonmembers (Order #72109).

Designed to accompany the **Basic Helping Skills** text, this manual provides guidance for the trainer of service providers. Information for trainers is presented in the form of additional content in the targeted areas, hints and suggestions for effective utilization of the training understanding and knowledge base.

ALSO AVAILABLE:

Counseling the Aged: A Training Syllabus for Educators (with index). Mary L. Ganikos, Editor. $15.75 to APGA members; 18.75 nonmembers (Order #72136).

Index to Counseling the Aged. $3.75 to APGA members; 4.75 nonmembers (Order #72010).

*Package price for all five volumes purchased together is $55.50 to APGA members; 68.50 nonmembers (Order #72111).

Ordering Information. Please specify titles, order number and your APGA membership number. Full payment, official institutional purchase order or charge information should accompany all orders. Charge information should be either for VISA or Mastercard and should include your account number, expiration date on card and your signature.

THE MATURING WOMAN

Aging has many negative connotations in our society, particularly for women. By the time the American woman reaches the ages 30-50 she is battling the effects of being told, however subtly, that her looks have faded, her career opportunities have diminished, and that she is no longer a desirable person.

"The Maturing Woman" is a stimulus film designed to help the viewer to identify attitudes and beliefs about getting older. Using a series of vignettes, the film explores how we view and limit ourselves, and how we are limited by others, by prevailing myths, stereotypes and media messages. It is designed to confront issues about aging and maturing, and to work toward a change in attitudes: our own and society's.

For women 18 to 80. 16mm, color and sound. 30 minutes. Rental fee per day of use $35. Sale price $345. Order #77568.

A Leader's Guide discusses different approaches to facilitating group response. One Leader's Guide is included with each film order.

Ordering information: When renting, please specify dates (first choice and two alternate choices) film will be shown. Please send your request accompanied by full payment or purchase order to:

American Personnel and
Guidance Association
Order Services Department
2 Skyline Place, Suite 400
5203 Leesburg Pike
Falls Church, VA 22041
Telephone 703/820-4700

"The Maturing Woman" was created and directed by Joan Pearlman and Joan Cohen; was produced and is distributed by APGA.

C. Gilbert Wrenn on Film

C. Gilbert Wrenn, during his outstanding career of over half a century, has been among the most influential and highly respected leaders in the guidance profession. Through his scholarly works (over 450 books and articles, including **The Counselor in a Changing World**) and his numerous leadership positions, he has made valuable contributions to the profession.

These films, by providing a comprehensive look at Wrenn's thoughts, give all serious students of counseling a chance to know this distinguished professional.

All three of the following films are approximately 30 minutes, 16mm, color and sound. Sale price for each is $345.00; rental fee per day of use for each is $35.00.

The Development of Modern Guidance With C. Gilbert Wrenn

During his long career in guidance Wrenn has viewed and participated in important counseling history. In this interview with John M. Whiteley, he discusses many developments that were interrelated and that made an impact on the growth of guidance. He covers books, events, movements, the founding of organizations and publications such as APGA and the **Personnel and Guidance Journal** and ends the film with a background of his own book, **The Counselor in a Changing World**.

This historical perspective given by such an outstanding leader in the field should prove invaluable for use in any course in the fundamentals of counseling. (Order #77579)

The Person of the Counselor — A Very Personal Perspective

Through this film the viewer gains many insights into Gilbert Wrenn as a person and as a counselor. Wrenn discusses with John Whiteley his own views that a counselor should: have a positive self image; have positive beliefs about others and about life; demonstrate concern and caring for others. This is an important film for practicum students and all counselors-in-training. (Order #77580)

The Future of Counseling

In this interview with John Whiteley, Wrenn focuses on some of the new areas of counseling that he sees developing as a result of current changes. He also discusses his feelings that people and relationships are becoming more important than theory and that counselor training must change to accommodate this trend. Wrenn recommends that counseling students have as much dealing with people as with books and ideas; that there should be more training settings outside the school, more practicums.

Used toward the end of fundamentals of counseling courses this film will help new students gain an understanding of how counseling is developing. (Order #77581)

Ordering Information: When renting, please specify dates (first choice and two alternate choices) film will be shown. Please send your request accompanied by full payment or purchase order to:

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